UNIVERSITY OF MARYLAND
LIBRARY
Founded 1813
SCHOOL OF MEDICINE

HEALTH SCIENCES LIBRARY
UNIVERSITY OF MARYLAND
BALTIMORE

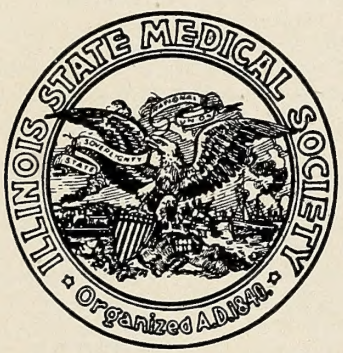

Digitized by the Internet Archive
in 2015

https://archive.org/details/illinoismedicalj1071illi

The Illinois Medical Journal

The Official Journal of

The Illinois State Medical Society



Index to Volume 107

January—June, 1955

‹ ›

Editor
Harold M. Camp
Monmouth, Illinois

Associate Editor
Theodore Van Dellen
Chicago, Illinois

Business Manager and Managing Editor
Mr. L. E. Malley
185 N. Wabash Avenue
Chicago 1, Illinois

Business Office
185 N. Wabash Avenue
Chicago 1, Illinois

Editorial Office
Medical Arts Building
Monmouth, Illinois

MEDICAL LIBRARY - UNIVERSITY OF MARYLAND

ILLINOIS STATE MEDICAL SOCIETY OFFICERS 1954-1955

President: Arkell M. Vaughn, 1180 East 63rd Street, Chicago
President-Elect: F. Garm Norbury, 1631 Mound Avenue, Jacksonville
1st Vice President: Louis R. Limarzi, 1853 West Polk St., Chicago
2nd Vice President: J. C. Redington, 306 East Main St., Galesburg
Secretary-Treasurer: Harold M. Camp, 224 South Main St., Monmouth

COUNCILORS

District		Term Expires
1	Carl E. Clark, Sycamore	1955
2	Joseph T. O'Neill, 628 Columbus Street, Ottawa	1956
3	F. Lee Stone, 30 N. Michigan Ave., Chicago	1956
3	Earl H. Blair, 6240 South Kedzie Ave., Chicago	1957
3	E. A. Piszczek, 6410 North Leona Ave., Chicago	1956
3	Raleigh C. Oldfield, 715 Lake Street, Oak Park	1957
3	John Lester Reichert, 1791 Howard Street, Chicago	1955
3	H. Close Hesseltine, 5841 South Maryland Ave., Chicago	1955
4	Charles P. Blair, 102 South First Street, Monmouth	1955
5	Jacob E. Reisch, 500 South 5th Street, Springfield	1955
6	Warner H. Newcomb, 316 West State Street, Jacksonville	1957
7	Arthur F. Goodyear, 132 South Water Street, Decatur	1955
8	Harlan English, 139 North Vermilion St., Danville	1955
9	Burtis E. Montgomery, Harrisburg	1957
10	Willard W. Fullerton, 101 N. Market St., Sparta	1957
11	Edwin S. Hamilton, 189 South Schuyler Ave., Kankakee	1956
	Councilor at Large — Willis I. Lewis, 218 North Park Avenue, Herrin	1955
	Chairman of the Council — Joseph T. O'Neill, 628 Columbus Street, Ottawa	

ILLINOIS MEDICAL JOURNAL

JOURNAL COMMITTEE—Harry M. Hedge, Chairman, Joseph T. O'Neill, Albert VanderKloot, John Lester Reichert, Paul R. Youngberg, R. C. Oldfield.
EDITORIAL BOARD—James H. Hutton, Chairman, J. J. Moore, Edwin M. Miller, Jacob E. Reisch, John R. Wolff, Frederick H. Falls, Raymond W. McNealy, Edward F. Webb, Arkell M. Vaughn, Edwin F. Hirsch, Kellogg Speed

MEDICAL SERVICE & PUBLIC RELATIONS

Percy E. Hopkins, Chairman.....800 W. 78th St., Chicago

MEDICO-LEGAL COMMITTEE

George C. Turner, Chairman..670 N. Michigan Ave., Chicago

MEDICAL TESTIMONY COMMITTEE

Oscar Hawkinson, Chairman.....1011 Lake St., Oak Park

PERMANENT COMMITTEE ON ARCHIVES

Tom Kirkwood, Chairman.....Lawrenceville
J. J. Moore, Secy., 55 E. Washington St.....Chicago
E. H. Weld.....Rockford

EDUCATIONAL COMMITTEE

Charles P. Blair, Chairman.....Monmouth
Karl L. Vehe, Co-Chairman...7001 N. Clark St., Chicago 26
Ann Fox, Secretary.....185 N. Wabash Ave., Chicago 1

SCIENTIFIC SERVICE COMMITTEE

Louis R. Limarzi, Chairman..185 N. Wabash Ave., Chicago 1

POST GRADUATE COMMITTEE

Louis R. Limarzi, Chairman..185 N. Wabash Ave., Chicago 1
George E. Kirby, Co-chairman.....Spring Valley

GENERAL COUNSEL

Mr. John W. Neal.....707 S. Wood St., Chicago
Assoc. Counsel, Mr. W. L. Oblinger, Reisch Bldg., Springfield

SECTION OFFICERS, 1954-1955

ALLERGY:

Chairman: Max Samter, 1853 West Polk Street, Chicago
Secretary: Ellis Canterbury, 333 Jefferson Building, Peoria

ANESTHESIOLOGY:

Chairman: Ernest F. Kreutzer, 407 Dwight Avenue, Joliet
Secretary: Arthur T. Shima, 532 North Oak Park Avenue, Oak Park
Alternate: E. M. Dewhirst, 607 North Logan Avenue, Danville

CARDIOVASCULAR DISEASE:

Chairman: V. Thomas Austin, 602 West University Avenue, Urbana
Secretary: Chauncey C. Maher, 6 North Michigan Avenue, Chicago

DERMATOLOGY:

Chairman: Hans M. Buley, 104 West Clark Street, Champaign
Secretary: Malcolm Spencer, 605 North Logan Avenue, Danville

EYE, EAR, NOSE AND THROAT:

Chairman: Philip R. McGrath, 331 Fulton Street, Peoria
Secretary: Fletcher Austin, 700 North Michigan Avenue, Chicago

MEDICINE:

Chairman: George Mason Parker, 410 Main Street, Peoria
Secretary: Jacques M. Smith, 720 North Michigan Avenue, Chicago

OBSTETRICS AND GYNECOLOGY:

Chairman: Howard L. Penning, 1315 North 5th Street, Springfield
Secretary: Charles D. Krause, 738 West 79th Street, Chicago

PATHOLOGY:

Chairman: Benjamin Markowitz, 219 North Main Street Bloomington
Secretary: Franklin J. Moore, 55 East Washington Street, Chicago

PEDIATRICS:

Chairman: Ralph H. Kunstadter, 104 South Michigan Avenue, Chicago
Secretary: J. Keller Mack, 614 South 7th Street, Springfield

PREVENTIVE MEDICINE AND PUBLIC HEALTH:

Chairman: R. F. Sondag, 1015½ Chestnut Street, Murphysboro
Secretary: Herbert Ratner, 129 Lake Street, Oak Park

RADIOLOGY:

Chairman: Elbert Kenneth Lewis, 6337 South Harvard Avenue, Chicago
Secretary: Fred Henry Decker, Methodist Hospital, Peoria

SURGERY:

Chairman: Howard P. Sloan, 203 North Main Street, Bloomington
Secretary: Cornelius M. Annan, 1180 East 63rd Street, Chicago

44950

Index to Volume 107

Issue	*Pages*	*Issue*	*Pages*
January	1-57	April	163-216
February	57-106	May	217-277
March	107-162	June	278-334

This Index is Arranged Under the Following Headings: AUTHORS, CORRESPONDENCE, DEATHS, EDITORIALS, MEDICAL ECONOMICS, NEWS OF STATE, ORIGINAL ARTICLES, and MEDICAL ABSTRACTS.

Authors

A

Afremow, Melvin L., 67

B

Bear, Stanley H., 236
Bernstein, Arthur, 87
Blender, Wm., 114
Bluefarb, Samuel M., 37
Bollinger, John A., 139
Boshes, Benjamin, 168
Brown, Ethen Allan, 287
Burgess, John, 292

C

Cannady, Edward W., 163
Cannon, Paul R., 234
Cohen, David M., 35
Cross, Roland R., 77, 178
Cross, Roland R., Jr., 271
Curtis, William W., 32

D

Darby, William J., 311
DeCosta, Edwin J., 123
Distelheim, Irving H., 35
Dolaz, E. J., 142
Dolehide, R. A., 142

E

Elghammer, W. R., 294

F

Fell, Egbert H., 315
Fitzgerald, James E., 123
Friedman, I. A., 142
Fullerton, W. W., 46

G

Garvin, John S., 171
Glorig, Aram, 10
Grier, Robert N., 123
Grimm, H. A., 6
Guy, Chester C., 62

H

Hardy, L. M., 217
Hirsch, Edwin R., 152
Hollender, Marc H., 20
Holt, Leonard, 37
Hutton, James H., 174

J

Jirka, Frank J., 84
Johnson, L. H., 245

K

Kagen, B.M., 120
King, Lester S., 130
Kraft, Adolph, 136

L

Lieberman, A., 89
Lobraico, Rocco V., 29

M

Maloney, W. Robert, 325
Milloy, Frank, 315
Mullen, Joseph J., 296

P

Perlman, Lawrence, 87
Peters, John, 64
Pierce, Paul P., 225
Pollard, H. M., 1
Porter, G. LeRoy, 57
Pulos, Peter, 87

R

Requarth, William, 206
Rostenberg, Adolph, 171
Rumore, Peter C., 24

S

Samuels, Thomas W., 84
Schuman, Leonard M., 107
Scrivner, Willard C., 123
Slaughter, Danely P., 139
Slepyan, Albert H., 17
Slobe, Frederick W., 96
Southwick, Harry W., 139
Spellberg, Mitchell A., 171
Sprenger, Lucille A., 240
Stoughton, Richard B., 299

T

Turow, Irving L., 73

V

Vaughn, Arkel M., 283

W

Waddington, Harry K., 171
Waife, S. O., 81
Walker, James S., 231
Wheeler, Douglas E., 10
Wolf, William, 136

Correspondence

Alergists Hold Annual Meeting 209
American Board of Obstetrics and Gynecology 156
American College of Chest Physicians, Annual Meeting of 209
American Goiter Association, Annual Meeting of .156
Annual Otolaryngologic Assembly 157
Clinics For Crippled Children Listed For—
February 49
March 101
April 156
May 208
June 275
July 327
Clinical Conference, Annual 99
Date to Remember, A 51
Emge Will Deliver Bacon Lecture 274
Fracture Course 157
General Practice Lectures 156
Good Use for Old Equipment 208
Illinois Tuberculosis Association Notes 102
Industrial Medicine, Comprehensive Course in 274
Invitation to Physicians' Wives 101
Medical Education and Licensure, Annual Conference on 50
Medical Partnerships, Prescription for 157
Medical Problems, Lectures and Discussions on Current 50
National Hospital Week 156
1955 College Essay Award Contest 102
Obstetrical and Gynecological Society, Annual Meeting of the Illinois 274
Ophthalmologists of the Americas to Meet in Santiago, Chile, in 1956 275
Parasitic Diseases, A Course in the Clinical Pathology and Pathology of 155
Plans Set for CME'S 1955 Convention in Los Angeles 51
Postgraduate Course on Diseases of the Chest 50
Proctologic Society Annual Meeting, American ..276
Rocky Mountain Cancer Conference 327
Rural Health, Tenth National Conference on 49
Television Program on Medical Research, New Ciba-Sponsored Weekly 50
"Treatment in Psychiatry", Ninth Lecture on 275
U. of I. Alumni Meeting 274
U.S. Civil Service Commission Positions 51
Woman's Auxiliary Plans for Annual Meeting ..155

Deaths

Adams, Iduma Ormond 282
Ascher, John Alfred 53
Baer, Joseph L. 55
Barothy, Arpad M. 333
Blodgett, Pliny R. 106
Brandle, Gustav E. 161
Bridge, Ozro 161
Burke, Thomas J. 161
Butner, Andrew J. 333
Calhoun, N. Curtis 282
Campbell, Robert K. 55
Cantle, Herbert Cuthbert 106
Cargill, Chauncey W. 333
Chandler, Fremont A. 106
Chittum, Jason D. 333
Cochran, Earl R. 55
Cohen, Mandel A. I. 216
Cole, Alvin Vernon 282
Cornell, John Webster 333
Davis, David John 106
Dawson, Julian 333
Denny, Alden R. 216
Doepp, Edward A. 55
Dorman, Henry P. 106
Dougherty, Leslie Dwight 106
Duff, Roden Robinson 282
Dunston, Edwin L. 333
Easton, Milo T. 333
Egan, Edward Merle 106
Fehr, Anton F. 216
Fish, William Otto 333
Frolick, Robert G. 55
Golub, Hymen William 106
Gould, Harold V. 216
Granger, Ernest Elmer 216
Griffiths, Evans H. 161
Hardinger, John D. 106
Hecht, Mannie Charles 55
Hewitt, William F. 282
Hill, Lewis R. 106
Hutchins, Linda K. 161
Irvin, Cyrus H. 216
Irwin, James Robert 216
Jacobs, Merrill R. 216
Johnson, Richard George 216
Kane, William W. 281
Kerr, George Austin 161
King, Maxwell B. 216
Klemme, John L. 333
Kloster, Grant M. 161
Knappenberger, George Emmett 106
Knappenberger, Gaillard 55
Lamb, James Garfield 161
Lambert, John V. 333
Landis, Clyde R. 106
LeBlanc, Florimond J. 216
Lester, Rollin Harold 333
Low, Abraham A. 55
MacDonald, Edward Joseph 161
Makar, Ignatius E. 333
Malley, John Albert 216
Mantell, Bernard 333
Mayes, Corwin Spencer 216
McCall, Harold Francis 216
McCarthy, David H. 333
McCaughey, Robert Stanton 55
Meisenheimer, Harold O. 216
Mershimer, William Clayton 281
Miller, John E. 333
Montgomery, Edmund Brewer 56
Morgans, Samuel Lewis 333

Muller, Fred H. 56
Murphy, John C. 333
Oppenheimer, Leo 56
Paradise, Fred A. 333
Parmuth, Samuel Abraham 56
Pollock, Arthur David 56
Polyak, Stephen 333
Pusch, Jerome B. 161
Raleigh, Gordon W. 334
Rettig, Frederick A. 106
Reuss, Harry Pierce 56
Rusk, John Alexander 281
Schaeffer, Louis E. 281
Schneider, Leo E. 334
Schwager, Isadore I. 56
Scott, Raymond G. 56
Seidel, Albert William 334
Shacter, Joseph Andrew 106
Shafer, Harry Lee 161
Spitze, Edward C. 161
Steffen, Richard Charles 162
Sterbini, Dominico 162
Stevenson, Frank H. 334
Stewart, Robert Hardy 56
Taylor, Arthur C. 282
Thompson, Frank P. 282
Tir, Morris I. 216
Trace, Isadore M. 334
Turek, James Charles 106
Ursich, Joseph Edward 56
Waters, Philip Sheridian 216
Wayland, Shipley 56
Wedel, Gustav F. L. 162
Welton, Carroll B. 162
Williams, William W. 216
Wong, Gene S. 56
Yampolsky, Rebecca Miriam 162
Yeakel, William K. 106
Zobrist, Benjamin Franklin 56

Editorials

A.M.A. Plans New Type Health Exhibits 324
Annual Meeting, The 1955 ..... 146, 184
Annual Meeting Illinois State Medical Society, Hotel Sherman, Chicago, May, 17, 18, 19, 20, 1955 149
Annual Meeting, Program For The 187
Another Illinois Physician Honored by His Community 185
Benign Gastric Ulcer, Diagnosis of 321
B12 Problems 184
Book Reviews, Jan. 50a, Feb. 58a, Mar. 62a, Apr. 48a
Committee on Industrial Health Resolution 93
Coronary Personality, The 41
Cross and State Health Department, Dinner Meeting Honors Roland R. 147
Davis, 1875-1954, David John 94
Don't Talk About the Treatment 145
Drug Reactions 268
Expensive Medicine 41
Foreign Medical Schools 92
Furey, Gold Medalist, Warren W. 42
Furey Receives Another Honor, Dr. Warren W. 186
Gangrene, Research in 145
Hemophilia, Reawakening of Interest in 268
Hall, the Death of Mrs. Andy 147
Hall's 90th Birthday, Andy 92
History of Medical Practice in Illinois 95
Illinois Medical Service, Continued Growth of 185
Isotope Know-How in New Courses, Doctors Will Get 44
Kendall County Medical Society Reorganized 322
Leary, James C. 323
Leukemia, The Treatment of Chronic 146
March of Dimes Against Polio, 1955 43
Maternal Welfare Committee for Illinois, Proposed 321
Medical Reservists to Receive Credits for Attendance at Annual A.M.A. Meeting 270
Montgomery, 1858-1954, Edmund Brewer 43
Muller, M.D., The Passing of Fred H. 42
Pfeiffenberger had an Interesting Trip, J. Mather 269
Presidential Inaugural Ceremony to be Broadcast 270
Secretaries' Conference, The Annual 267
Statistics 185
Television in Postgraduate Medical Education 44
Tuberculosis Hospital, Dedication of the Suburban Cook County 186

Medical Economics

Coroner's Act of the State of Illinois, A Proposed Revision of the, (Hirsch) 152
General Practice, (Fullerton) 46
Insurance Plan, Evolution of a Community Health, (Requarth) 206
Medical Charities, (Cross Jr.) 271
Nursing Scholarship, (Malony) 325
Workmen's Compensation System Satisfactory?, Is Our, (Slobe) 96

News of the State

Coming Meetings, Personals, Deaths 52, 103, 158, 217, 277, 329

Original Articles

Allergic Manifestations, Emotional Aspects of, (Turow) 73
Allergy and the General Practitioner, (Brown & Colombo) 287
Appendiceal Masses in Children, Cook County Hospital Case Records. One Hundred Consecutive, (Milloy & Fell) 315
Arthritic; Successful Result with Massive Cortisone Therapy, (Case Report), A Psoriatic Rheumatoid, (Liebermann) 89
Bacterial Endocarditis, 1948-1952, A Review of 202 Cases of, (Afremow) 67

Cancer, (Seminar), The Physician, The Patient and, (Hollender) 20
Cesarean Sections in a Nonteaching General Hospital, (Curtis) 32
Chronic Erythematosus with Atabrine and Chloroquine, Treatment of, (Stoughton) 299
Comedones in Acne Vulgaris with High Frequency Current, Treatment of, (Rosenberg) 181
Combined Treatment with N-Allylnormorphine and L-Arterenol Controlled with Methadone Poisoning, (Case Report), (Pulosi, Bernstein & Perlman) 87
Cytology, Its Practical Application in Gynecologic Diagnosis, (Grimm) 6
Cystic Fibrosis of the Pancreas Eccrinosis, (Kagan) 120
Diabetes Mellitus, Recognition and Diagnosis of, (Sprenger) 240
Diarrhea, Bacterial, (Burgess) 292
Diarrhea, Virus (Elghammer) 294
Diagnostic Value of Pain in Nonpenetrating Abdominal Injuries, The, (Guy) 62
Emergency Tracheal and Bronchial Conditions, (Bear) 236
Epidemic Intelligence, (Schuman) 107
Erythema Multiforme Bullosum Following Phenylbutazone Therapy, (Case Report) (Bluefarb & Holt) 37
Exophthalmos Associated with Thyroid Disease, (Porter & Walker) 57
Fibrinolysis in Patients with Metastatic Carcinoma of the Prostate Gland, (Cook County Hospital Case Records), (Dolaz, Dolehide & Friedman) ..142
Fistulas, External Pancreatic, (Rumore) 24
General Practitioner, The, (Johnson) 245
Glucagon, (Waife) 81
Hemangioma, An Evaluation of the Treatment of the, (Slepyan) 17
Hemorrhage from the Upper Gastrointestinal Tract, (Pollard) 1
Hypertension, Combined Drug Therapy in, (Cannady) 163
Idiopathis Hypertrophic Phloric Stenosis in an Elderly Adult, (Case Report) (Southwick, Slaughter & Bollinger) 139
Illinois Department of Public Health, The, (Cross) 178
Illinois Medicine, Early, (Hutton) 174
Labor, A Symposium, Elective Induction of, (Grier, Scriver, DeCosta & Fitzgerald) 123
Mitral Valvulotomy Indications for, (Grissom) ..308
Neuropsychiatrist in the General Hospital, The, (Boshes) 168
Noise Problem, An Introduction to the Industrial, (Glorig & Wheeler) 10
Nutrition, What Lies Ahead in the Field of, (Darby) 311
Ocular Manifestations in the Mentally Deficient, (Kamenetz) 302
Ocular Motility, Accommodations and Problems in, (Cushman & Jarrett) 305
Ophthalmology in General Practice, (Blender) 114
Otolaryngology, The Failure of Antibiotics and Chemotherapy in, (Walker) 231
Overtreatment as a Cause of Disease, A Symposium, (Garvin, Rostenberg, Spellberg & Waddington) .171
Personality of Medical Practice, The, (Vaughn) ..283
Practise of Medicine in 1787, The, (King) 130
Protein Metabolism, Potassium-Sodium Relationship in, (Cannon) 234
Public Health, Looking Forward in, (Cross) 77
Reichstein's Substance S Acetate — A New Therapeutic Agent, (Peters) 64
Respiratory Tract Infections, The Rational Use of Antibiotics and Sulfonamides in the Treatment of, (Pierce) 225
Respiratory Infections in Children, A Controlled Study in the Uses of Chemotherapeutic and Antibiotic Agents in Uncomplicated Upper, (Traisman) 221
Respiratory Infections in Children and the Promiscuous Use of Chemotherapeutic and Antibiotic Agents, Uncomplicated Upper, (Hardy) 217
Retroperitoneal Cystadenoma of the Ovary (Cook County Hospital Case Records) (Jirka & Samuels) 84
Rh Problem in Obstetrics, The, (Mullen) 296
Symposium on the Uses and Abuses of Chemotherapy and Antibiotic Agents for Infections in Children 217
Tabes Dorsalis Controlled with ACTH and Cortisone, (Case Report), Lightning Pains of, (Distelheim & Cohen) 35
Thyroiditis, Diagnosis and Treatment of, (Kraft & Wolf) 13
Varices in Pregnancy, Management of, (Lobraico) . 29

The P.R. Page

March 154

Table of Contents

JANUARY, 1955
Vol. 107, No. 1

Editor
Harold M. Camp
Monmouth, Illinois

Associate Editor
Theodore Van Dellen
Chicago, Illinois

Business Manager and Managing Editor
Mr. L. E. Malley
185 N. Wabash Avenue
Chicago 1, Illinois

Business Office
185 N. Wabash Avenue
Chicago 1, Illinois

Editorial Office
Medical Arts Building
Monmouth, Illinois

Send original articles and membership correspondence to Harold M. Camp, Monmouth, Ill.

Send changes in the mailing list to Managing Editor, 185 N. Wabash Ave., Chicago 1, Ill.

Subscription price of this JOURNAL to persons not members of the Illinois State Medical Society is $4.00 per year, in advance, postage prepaid, for the United States, Cuba, Puerto Rico, Philippine Islands, Hawaiian Islands and Mexico. $5.00 per year for all foreign countries included in the postal union. Canada, $4.50. Single current copies 50 cents. By mail, 60 cents.

ORIGINAL ARTICLES

Hemorrhage from the Upper Gastrointestinal Tract. H. M. Pollard, M.D., Ann Arbor, Michigan 1
Cytology, Its Practical Application in Gynecologic Diagnosis. H. A. Grimm, M.D., Chicago 6
An Introduction to the Industrial Noise Problem. Aram Glorig, M.D., and Douglas E. Wheeler, Ph.D., Los Angeles, California 10
An Evaluation of the Treatment of the Hemangioma. Albert H. Slepyan, M.D., Highland Park 17
The Physician, The Patient and Cancer, (Seminar) Marc H. Hollender, M.D., Chicago 20
External Pancreatic Fistulas. Peter C. Rumore, M.D., Effingham . 24
Management of Varices in Pregnancy. Rocco V. Lobraico, Jr., M.D., F.A.C.S., Chicago 29
Cesarean Sections in a Nonteaching General Hospital. William W. Curtis, M.D., Springfield 32
Lightning Pains of Tabes Dorsalis Controlled with ACTH and Cortisone. (Case Report) Irving H. Distelheim, M.D., and David M. Cohen, M.D., Chicago 35
Erythema Multiforme Bullosum Following Phenylbutazone Therapy. (Case Report) Samuel M. Bluefarb, M.D., and Leonard Holt, M.D., Chicago 37

EDITORIALS

The coronary personality 41
Expensive medicine 41
Warren W. Furey—Gold Medalist 42
The passing of Fred H. Muller, M.D. 42
Edmund Brewer Montgomery, 1858-1954 43
1955 Illinois March of Dimes against polio 43
Television in postgraduate medical education 44
Doctors will get isotype know-how in new courses 44
Book reviews 50

MEDICAL ECONOMICS

General Practice, W. W. Fullerton, M.D., Sparta 46

CORRESPONDENCE

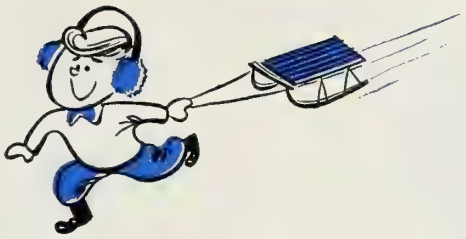
Clinics for crippled children listed for February 49
Tenth National Conference on Rural Health 49
Postgraduate course on diseases of the chest 50
Annual Conference on Medical Education and Licensure 50
Lectures and discussions on current medical problems 50
New Ciba-sponsored weekly television program on medical research .. 50
A date to remember 51
U. S. Civil Service Commission positions 51
Plans set for CME's 1955 convention in Los Angeles 51

NEWS OF THE STATE 52

Re-entered as Second-Class Matter November 12, 1952 at the Post Office, Mendota, Illinois, under the Act of March 8, 1879. Acceptance for mailing at special rate postage provided for in section 1102, Act of October 8, 1917, authorized July 15, 1918. Printed monthly by The Wayside Press, Mendota, Illinois. Office of Publication, 1501 W. Washington Road, Mendota, Illinois. POSTMASTER — Return undeliverable copies under form 3579 to 1501 W. Washington Road, Mendota, Illinois.



They've heard the call for



A full day's serving of eight important vitamins (including 3 mcg. of body-building B_{12}) in each spoonful. Delicious lemon-candy flavor and aroma. No pre-mixing, no droppers, no refrigeration. Mixes easily in milk, cereals or juices. Now with B_6 added. Sold in 90-cc., 8-fluid-ounce and economical one-pint bottles.

Abbott®

VI-DAYLIN®

(HOMOGENIZED MIXTURE OF VITAMINS A, D, B_1, B_2, B_6, B_{12}, C AND NICOTINAMIDE, ABBOTT)

the nutritional formula for growing children

Each 5-cc. teaspoonful of Vi-Daylin contains:

Vitamin A	3000 U.S.P. units
Vitamin D	800 U.S.P. units
Thiamine Hydrochloride	1.5 mg.
Riboflavin	1.2 mg.
Pyridoxine Hydrochloride	0.5 mg.
Ascorbic Acid	40 mg.
Vitamin B_{12}	3 mcg.
Nicotinamide	10 mg.

501057

ILLINOIS STATE MEDICAL SOCIETY OFFICERS 1954-1955

President: Arkell M. Vaughn, 1180 East 63rd Street, Chicago
President-Elect: F. Garm Norbury, 1631 Mound Avenue, Jacksonville
1st Vice President: Louis R. Limarzi, 1853 West Polk St., Chicago
2nd Vice President: J. C. Redington, 306 East Main St., Galesburg
Secretary-Treasurer: Harold M. Camp, 224 South Main St., Monmouth

COUNCILORS

District		Term Expires
1	Carl E. Clark, Sycamore	1955
2	Joseph T. O'Neill, 628 Columbus Street, Ottawa	1956
3	F. Lee Stone, 30 N. Michigan Ave., Chicago	1956
3	Earl H. Blair, 6240 South Kedzie Ave., Chicago	1957
3	E. A. Piszczek, 6410 North Leona Ave., Chicago	1956
3	Raleigh C. Oldfield, 715 Lake Street, Oak Park	1957
3	John Lester Reichert, 1791 Howard Street, Chicago	1955
3	H. Close Hesseltine, 5841 South Maryland Ave., Chicago	1955
4	Charles P. Blair, 102 South First Street, Monmouth	1955
5	Jacob E. Reisch, 500 South 5th Street, Springfield	1955
6	Warner H. Newcomb, 316 West State Street, Jacksonville	1957
7	Arthur F. Goodyear, 132 South Water Street, Decatur	1955
8	Harlan English, 139 North Vermilion St., Danville	1955
9	Burtis E. Montgomery, Harrisburg	1957
10	Willard W. Fullerton, 101 N. Market St., Sparta	1957
11	Edwin S. Hamilton, 189 South Schuyler Ave., Kankakee	1956
	Councilor at Large — Willis I. Lewis, 218 North Park Avenue, Herrin	1955
	Chairman of the Council — Joseph T. O'Neill, 628 Columbus Street, Ottawa	

ILLINOIS MEDICAL JOURNAL

JOURNAL COMMITTEE—Harry M. Hedge, Chairman, Joseph T. O'Neill, Albert VanderKloot, John Lester Reichert, Paul R. Youngberg, R. C. Oldfield.
EDITORIAL BOARD—James H. Hutton, Chairman, J. J. Moore, Edwin M. Miller, Jacob E. Reisch, John R. Wolff, Frederick H. Falls, Raymond W. McNealy, Edward F. Webb, Arkell M. Vaughn, Edwin F. Hirsch, Kellogg Speed

MEDICAL SERVICE & PUBLIC RELATIONS

Percy E. Hopkins, Chairman.....800 W. 78th St., Chicago
Mr. J. C. Leary, Pub. Rela. Coun., 185 N. Wabash, Chicago

MEDICO-LEGAL COMMITTEE

George C. Turner, Chairman..670 N. Michigan Ave., Chicago

MEDICAL TESTIMONY COMMITTEE

Oscar Hawkinson, Chairman.....1011 Lake St., Oak Park

PERMANENT COMMITTEE ON ARCHIVES

Tom Kirkwood, Chairman.....Lawrenceville
J. J. Moore, Secy., 55 E. Washington St.....Chicago
E. H. Weld.....Rockford

EDUCATIONAL COMMITTEE

Charles P. Blair, Chairman.....Monmouth
Karl L. Vehe, Co-Chairman...7001 N. Clark St., Chicago 26
Ann Fox, Secretary.....185 N. Wabash Ave., Chicago 1

SCIENTIFIC SERVICE COMMITTEE

Louis R. Limarzi, Chairman..185 N. Wabash Ave., Chicago 1

POST GRADUATE COMMITTEE

Louis R. Limarzi, Chairman..185 N. Wabash Ave., Chicago 1
George E. Kirby, Co-chairman.....Spring Valley

GENERAL COUNSEL

Mr. John W. Neal.....707 S. Wood St., Chicago
Assoc. Counsel, Mr. W. L. Oblinger, Reisch Bldg., Springfield

SECTION OFFICERS, 1954-1955

ALLERGY:

Chairman: Max Samter, 1853 West Polk Street, Chicago
Secretary: Ellis Canterbury, 333 Jefferson Building, Peoria

ANESTHESIOLOGY:

Chairman: Ernest F. Kreutzer, 407 Dwight Avenue, Joliet
Secretary: Arthur T. Shima, 532 North Oak Park Avenue, Oak Park
Alternate: E. M. Dewhirst, 607 North Logan Avenue, Danville

CARDIOVASCULAR DISEASE:

Chairman: V. Thomas Austin, 602 West University Avenue, Urbana
Secretary: Chauncey C. Maher, 6 North Michigan Avenue, Chicago

DERMATOLOGY:

Chairman: Hans M. Buley, 104 West Clark Street, Champaign
Secretary: Malcolm Spencer, 605 North Logan Avenue, Danville

EYE, EAR, NOSE AND THROAT:

Chairman: Philip R. McGrath, 331 Fulton Street, Peoria
Secretary: Fletcher Austin, 700 North Michigan Avenue, Chicago

MEDICINE:

Chairman: George Mason Parker, 410 Main Street, Peoria
Secretary: Jacques M. Smith, 720 North Michigan Avenue, Chicago

OBSTETRICS AND GYNECOLOGY:

Chairman: Howard L. Penning, 1315 North 5th Street, Springfield
Secretary: Charles D. Krause, 738 West 79th Street, Chicago

PATHOLOGY:

Chairman: Benjamin Markowitz, 219 North Main Street Bloomington
Secretary: Franklin J. Moore, 55 East Washington Street, Chicago

PEDIATRICS:

Chairman: Ralph H. Kunstadter, 104 South Michigan Avenue, Chicago
Secretary: J. Keller Mack, 614 South 7th Street, Springfield

PREVENTIVE MEDICINE AND PUBLIC HEALTH:

Chairman: R. F. Sondag, 1015½ Chestnut Street, Murphysboro
Secretary: Herbert Ratner, 129 Lake Street, Oak Park

RADIOLOGY:

Chairman: Elbert Kenneth Lewis, 6337 South Harvard Avenue, Chicago
Secretary: Fred Henry Decker, Methodist Hospital, Peoria

SURGERY:

Chairman: Howard P. Sloan, 203 North Main Street, Bloomington
Secretary: Cornelius M. Annan, 1180 East 63rd Street, Chicago

The
ILLINOIS
Medical Journal

Official Journal of The Illinois State Medical Society

JANUARY 1955
VOL. 107 NO. 1

HEMORRHAGE from the Upper Gastrointestinal Tract

H. M. Pollard, M.D., Ann Arbor, Michigan

THOSE of you here this afternoon can testify to the fact that loss of blood from the gastrointestinal tract still constitutes an emergency in the minds of the patient, the family, as well as the physician. It should be remembered, however, that as little as 80 to 100 cc. of blood placed in the gastrointestinal tract is capable of producing a black tarry stool. Taking this as the minimum, it remains quite difficult to actually estimate the total amount of blood loss other than evaluating the physical findings and taking the patient's story of how much he vomited.

In dealing with the problem of upper gastrointestinal hemorrhage, two things should invariably be established at an early date. First, a careful estimate should be made as to the approximate amount of blood loss. If the hemorrhage has manifested itself only by melena this is practically impossible other than by evaluating the patient's physical status. If there has been hematemesis then we can make some rough estimate, but as one would anticipate, the amount is usually exaggerated by the patient. The second major problem is to make a quick deduction as to the source of the hemorrhage.

The severity of the hemorrhage can be estimated in a large measure by the physician's own ability, including his five senses. Patients losing only a small amount of blood may not demonstrate any alteration in their appearance or in their physical findings. However, there is the profound case whose physical findings reveal the features described by Fisher[1] in 1870 "consisting of a pale marble appearance to the skin, bluish tinge to the lips, large drops of sweat on the forehead and the whole body feels cold. His sensibility is much blunted. The pulse of these people may be almost imperceptible and very rapid. The arteries are small and tension very low. The patient is conscious, but replies slowly and only when repeatedly and importunely questioned".

In making a quick evaluation of the source of hemorrhage one, of course, of necessity must obtain complete studies for a differential diagnosis of all lesions affecting the esophagus, stomach, duodenum, and even the upper portion of

From the Department of Internal Medicine, University Hospital, University of Michigan Medical School, Ann Arbor, Michigan.

Oration in Medicine. Presented before the General Assembly 112th Annual Meeting, Illinois State Medical Society, Chicago, May 20, 1954.

the small bowel. It should be kept in mind, however, that gastroduodenal ulceration probably constitutes seventy to seventy-five per cent of all upper gastroitestinal hemorrhages. The next potential source is esophageal varices, following this gastritis, and then a miscellaneous group, including gastric carcinoma, leiomyoma, and through the list of unusual lesions. Finally, there is the significant group of so-called "source unknown". In some reports this constitutes as high as twenty-five per cent of the entire group. If pursued, many of these cases are found to be shallow superficial ulcerations and, as all of you well know, in some cases no lesion is ever detected either at postmortem examination or on the operating table.

When faced with a patient bleeding from a gastroduodenal ulcer, this individual will usually give a fairly typical history of symptoms going back for some period of time. However, in the neighborhood of sixteen per cent of all ulcer patients will have a hemorrhage as their initial manifestation of the disease. The patient with esophageal varices will usually give an alcoholic history, or he may show a mild degree of jaundice from some other type of cirrhosis. The patient with gastritis constitutes part of a significant group and some figures quote this group as high as eighteen per cent of all individuals having upper gastrointestinal tract hemorrhage. To me this group has been particularly intriguing, since I have seen superficial erosions superimposed upon the hypertrophic gastritis. At the operating table I have seen the stomach opened in search for the source of hemorrhage, to find that the entire gastric mucosa was oozing blood, similar to what may be seen in patients with chronic ulcerative colitis. The miscellaneous group of individuals with varying types of lesions, such as gastric carcinoma, may give a history suggesting such a possibility. A more benign lesion, such as a polyp, fibroma, leiomyoma, may not give any pre-existing history. Patients with acute ulcer, acute erosion, or shallow ulcer, frequently do not give any preceding history and the detection of such a lesion is not common until it is either seen through the gastroscope or found by the surgeon, such as is mentioned by Cooper and Ferguson[2].

ESTABLISHING THE DIAGNOSIS

It is imperative to make every effort to establish the diagnosis at the beginning, in order to arrive at the proper course of therapy and to make the decision as to whether this should be medical or surgical. The customary complete blood count will assist in revealing the possibility of a blood dyscrasia and a hematocrit will, of course, give some estimation as to the severity of the hemorrhage. The standard urinalysis may reveal the presence of albumin and casts and suggest the possibility of uremia. The Hampton x-ray technique, as further elaborated upon by Schatzki[3], whereby the patient has a fluoroscopic examination of the upper digestive tract within twenty-four to forty-eight hours without manipulation, is of inestimable value. Although this examination may not finally establish the diagnosis, there is a good probability that in seventy per cent of the cases the source of the hemorrhage will be detected by this means. Gastroscopic examinations have been performed by ourselves and by others within the first twenty-four to forty-eight hours without harm to the patient and this procedure sometimes makes it possible to detect early acute ulcer and sometimes erosion. The severity of the hemorrhage is the deciding factor as to whether or not this procedure can be done with comparative safety to the patient. Bedside esophagoscopy has been proposed and may be of value, particularly where varices are suspected.

Other laboratory procedures that can be done without discomfort to the patient consist of a non-protein-nitrogen, which gives an estimation of any renal pathology and also extrarenal azotemia, a bromsulphathalein liver function test, which is of distinct value in the differential diagnosis, since retention will suggest the possibility of liver disease. Approximately sixteen per cent of cirrhotic patients may in addition have a duodenal ulcer.

GASTRODUODENAL ULCER

I should like to discuss the major group consisting of seventy to seventy-five per cent of patients who bleed from a gastroduodenal ulcer. There are various figures which indicate that on the average twenty-five per cent of all ulcer patients will bleed. Actually, the longer the ulcer history, the higher is the incidence of hemorrhage and an individual with peptic ulcer of

forty years' duration has an approximate ninety per cent chance[4] of having a hemmorrhage.

There are a few statistical items of interest in connection with hemorrhage, such as the fact that duodenal ulcer bleeding is more common than gastric ulcer bleeding. The mortality, however, is higher from gastric ulcer than from duodenal ulcer bleeding, the ratio being nineteen per cent in gastric ulcer versus eight per cent in duodenal ulcer[5]. Recurrent bleeding from an ulcer, particularly after admission to the hospital and while the patient is under medical treatment, is significantly ominous, since the mortality in individuals with recurrent bleeding may be as high as twenty per cent. If we concern ourselves with mortality by age distribution, we have the figures of Jones[5], as follows:

Under 30	2.5 per cent
30 - 39	1.2 per cent
40 - 49	4.1 per cent
50 - 59	5.5 per cent
60 - 69	12.5 per cent
70 and over	21.3 per cent

Although many people speak of the break as occurring over the age of forty-five, these figures make the significant statistical change at the age of sixty, rather than below.

Individuals with melena do not carry as great a mortality as those with hematemesis. A recent report by Crohn[6] indicates four per cent versus twenty per cent in a series of 2800 cases of severe bleeding. From the literature in the presence of all averages the mortality was 10.3 per cent. The figures from our own clinic in 180 cases of severe hemorrhage showed a mortality of 12.9 per cent.

TREATMENT OF GASTRODUODENAL HEMORRHAGE

I am in complete agreement with Crohn[6] when he states that mild or moderate hemorrhage requires simple treatment and is accomplished by almost no direct mortality. There has been general agreement to concentrate attention and statistics on severe massive exsanguinating hemorrhage. Severe hemorrhage constitutes less than one-third of the cases in the entire group and consists of those in whom the red blood cell count is 3,000,000 or less, the hemoglobin 7.5 gms./100 cc., and the hematocrit 25 or less. For years a controversy has existed regarding the use of morphine, blood transfusions, early feeding, and surgery in the management of patients with severe hemorrhage. There is, however, general agreement that initially the patient should be hospitalized and placed at bed rest.

Morphine — My preference in sedation is for sodium phenobarbital, 0.1 gram, hypodermically. This may be repeated as often as every six hours. I am opposed to the use of morphine unless it is combined with atropine, inasmuch as pharmacologically morphine alone is spasmogenic to smooth muscles. It decreases respiration, thereby promoting anoxia, and in some instances it stimulates reversed peristalsis and vomiting.

Early Feeding — Prompt feeding is a highly desirable form of treatment. It is particularly advantageous since it prevents dehydration. It furnishes nutrition which is, likewise, reassuring to the patient. It diminishes peristalsis and serves as a neutralizing agent to acid. This program, re-emphasized by Meulengracht in 1935[7], is quite simple. I should like to quote the diet outlined by Dr. Meulengracht, as follows:

6 a.m. — Tea, white bread, and butter.
9 a.m. — Oatmeal with milk, white bread, and butter.
1 p.m. — Dinner.
3 p.m. — Cocoa.
6 p.m. — White bread, butter, sliced meats, cheese and tea.

Alkalis and non-absorbable alkalis are advisable and almost any of them are suitable. Antisecretory agents, including atropine, are, likewise, desirable and should be administered. I include either atropine, tincture of belladonna, or many of the more recently introduced anticholinergic drugs.

Transfusion — Transfusion continues to be a controversial issue. It is interesting to note that the feeding regimen of Meulengracht was introduced in 1935 and the slow-drip blood transfusion technique was, likewise, introduced in 1935 by Marriott and Kekwich[8]. Since the introduction of these two methods of therapy, medical management of upper gastrointestinal hemorrhage has improved, but almost no evidence is available in the literature as to which one of these items has influenced the decrease in mortality. Meulengracht in his original article states that "the patients are allowed to eat as much as they want". In a few cases (12 out of 286) where large quantities of blood have

been lost, they have been given one or two blood transfusions soon after admission to the hospital. (His statement to me was that he gives 250 cc. of blood per transfusion). In his 251 cases of bleeding from ulcer he had three deaths, that is, one per cent mortality. He compared this with Christiansen's[7] 7.9 per cent mortality in a similarly treated group of patients without food being utilized. In our own clinic we compared 59 cases treated by no transfusions for forty-eight hours, but with food, with a mortality of 3.3 per cent to a similarly treated group who had food plus transfusions, with a mortality of 24.5 per cent. The particular feature of transfusions which concerns me is the so-called massive, rapid, or multiple transfusions that are now proposed for the management of upper gastrointestinal hemorrhage. I should like to mention a case recently reported by Warthin[9] "who was that of a 64-year-old mechanic in shock on arrival from hematemesis and melena. However, two liters of blood affected normal circulation. Four hours later bleeding recurred and despite four simultaneous transfusions under pressure blood poured from mouth and anus, and death ensued in less than an hour". If my calculations are correct, this patient received a total of 4000 cc. of blood in a matter of six to eight hours. I raise the question as to whether or not it is even possible for clotting to occur with such a rapid inflow of blood into the general circulation. Lipp[10] states that a patient who has massive continuing hemorrhage with a picture of collapse should immediately have multiple transfusions in addition to the usual supportive therapy — with as much as 2000 cc. of blood being administered in an hour, if necessary.

Almost all authors now reporting on the management of upper gastrointestinal hemorrhage conclude with the statement, "Now that massive transfusions are the accepted form of treatment. . . . . .". However, the literature is almost completely devoid of any true comparison of cases treated with food and with delayed transfusions. One other item, admitting that it may be minor, but which must be kept in mind in the presence of hemotherapy, is the possible production of homologous serum jaundice, transfusion reaction, and isosensitization.

PHYSIOLOGICAL MECHANISM OF HEMORRHAGE

The normal blood pressure and blood volume for ordinary conditions may not necessarily be the normal or most advantageous blood pressure or blood volume for the conditions prevailing following a major loss of blood. Defensive mechanisms are called into place which we may override by massive transfusions. The addition of blood to the circulatory system during circulatory rest causes an equal increase in the static pressure throughout the system. After large transfusions the amount of blood and thereby the static pressure of the veins, might become too great, causing abnormal distension of the right ventricle during diastole. Under other conditions, such as that following a hematemesis, the venous blood volume and static blood volume might be so reduced that the right ventricle would no longer be filled during diastole. Several blood reservoirs exist and these have various respective mechanisms for changing their capacity, but with a change in capacity of one or more of these blood reservoirs, the static capacity of the whole circulatory system may be altered so as to fit itself to the volume of blood present and thereby maintain a suitable hydrostatic pressure in the central system veins. Both the arteries and the veins are supplied with circularly arranged smooth muscle fiber. By their contraction they may diminish the overall capacity of the circulatory system and thereby increase the hydrostatic pressure of the contained blood. The blood vessels are a reservoir, as are the spleen and the capillaries. An animal may be bled suddenly to the extent of some thirty to forty per cent of its calculated blood volume and recover without assistance. The physiological compensatory mechanisms, vaso-constriction and uptake of fluid from the tissues are subject to restore the blood pressure and blood volume to normal. These are some of the few physiological features which point to the fact that the human mechanism is capable of major adjustment following a hemorrhage, a protective mechanism.

EMERGENCY SURGERY FOR SEVERE GASTRODUODENAL ULCER

Surgical treatment, to be effective[2] must be undertaken during the first twenty-four to forty-eight hours after the onset of hemorrhage. It is particularly indicated in patients over sixty years of age, where there is evidence of either continuous bleeding or recurrence of bleeding, particularly while the patient is in the hospital

under medical management. There is increasing interest in the surgical approach to this disease, particularly in unexplained cases and a surgeon should be in constant attendance in the management of many of these problems.

CONCLUSIONS

1. In bleeding from gastroduodenal ulcers, the patient with sclerotic vessels should be watched closely.

2. Morphine should be avoided.

3. Early feeding should be employed.

4. Transfusions are valuable, but there is reason to believe that the massive rapid transfusion is not indicated and that following some delay small transfusions by the drip technique are to be desired.

5. Emergency surgery in the presence of recurrent or continuous hemorrhage should be given serious consideration.

REFERENCES

1. Fischer, Hermann. "Remarks On Shock". **St. Louis Medical and Surgical Journal,** n.s. **12**:68-78, 120-130, 1875. (Translated from the German by Edward Evers, M.D., St. Louis — Fischer, Hermann, "Ueber den Shok. Sammlung Klinischer Vortraege". 10 Chirugie No. **5**: 69-82. Vortrag, gehalten in der chirurgischen Klinik zu Breslau, ende Januar 1870).
2. Cooper, D. R., and Ferguson, L. K. "Gastric Resection for Upper Gastrointestinal Hemorrhage of Undetermined Cause". **J.A.M.A. 151**:879-884, March 14, 1953.
3. Schatzki, R. "Roentgenologic Examination of Patients with Bleeding from Gastrointestinal Tract". **New Eng. J. Med. 235**:783-786, 1946.
4. Stolte, J. B. "Gross Bleeding from Digestive Tract. Frequency of Manifest Bleeding in Peptic Ulcer, with Regard to Duration of Disease and to Age of Diseased". **Acta Med. Scandinav. 116**:584-593, 1944.
5. Jones, F. Avery, "Modern Trends in Gastroenterology" Paul B. Hoeber, Inc. 1952.
6. Crohn, B. C., "Need for Aggressive Therapy in Massive Upper G.I. Hemorrhage". **J.A.M.A. 151**:625-29, February 21, 1953.
7. Meulengracht, E. "Treatment of Haemetemesis and Melaena with Food". **Lancet 2**:1220-1222 November 30, 1935.
8. Marriott, H. L., and Kekwich, A. "Continuous Drip Blood Transfusion, with Case Records of very Large Transfusions". **Lancet 1**:977-981, April 27, 1935.
9. Warthen, T. A., Ross, F. P., Baker, D. V., and Wissing, E., "The Management of Upper G.I. Hemorrhage". **Ann. of Int. Med.** Vol. 39, p. 241-253, August, 1953.
10. Lipp, W. F., Milch, E., and Aaron, A. H. "The Management of Massive Hemorrhage from Gastroduodenal Ulceration". **N. Y. State J. of Med. 52**:2261-2264, September 15, 1952.

‹‹‹ ›››

Don't confuse the patient

And so the object of our sympathies wonders where that patient-confidence, that patient-trust have gone when the physician is asked such questions as these: "Have you heard of the sex hormones as a cure for cancer?" or "Do you think hyaluronidase (he can't even pronounce the word) will save me from an operation for kidney stone?" or "Where can my father receive radioactive isotope treatment?" This physician has tried to keep abreast of medical progress but appears that while he has been traveling on an internal combustion power plant, the rest of the world has shifted to jet propulsion. *Editorial, The Physician's Dilemma. Geriatrics, Aug.* 1954.

Psychosomatic backache

Sometimes the examining physician is prone to make a diagnosis of psychosomatic backache because he is unable to find any pathological cause for the backache; and subsequently some colleague finds a metastatic carcinoma from the prostate or the patient is found to have an abscess or beginning tuberculosis of the spine. It behooves everyone to be careful and use the diagnosis of psychosomatic backache only when all possible sources of pathology and etiology have been eliminated. Only by being most careful and scrupulous about such a diagnosis, is one going to avoid unnecessary harm to everyone in the treatment of backache. *Carl Scuderi, M.D., Backache. J. Oklahoma M.A., July* 1954.

CYTOLOGY

Its Practical Application in Gynecologic Diagnosis

H. A. Grimm, M.D., Chicago

THE preparation and interpretation of cytologic smears from the female genital tract has made available a most valuable method for early cancer detection. A brief review of some of the practical aspects of technique and application is the purpose of this presentation. The discussion will be limited to five considerations: 1) the proper preparation of smears; 2) the clinical meaning of cytologic interpretations; 3) the use of cytology in practice; 4) the problem of carcinoma in situ of the cervix and 5) confirmatory diagnostic methods.

1. *What Precautions Are Necessary For Proper Preparation of Smears?* The most important discovery of Dr. Papanicolaou was not his staining technique but his method of fixation, which is the best method yet known for preserving cells. It is the responsibility of the clinician taking smears to make sure that the specimens are adequate and that they are properly fixed. The two most common handicaps against which the cytologist must work are: inadequate sampling, and drying of the smears before fixation. Before smears are obtained all materials should be ready and at hand. We recommend that two samples be obtained: one from the vaginal pool and one from the cervical os, by using either a cotton tipped swab or an appropriate wooden spatula. Adequate material from the cervix should be obtained from the entire circumference of the cervical os spreading the material thinly and evenly over most of the slide. The slides are immersed immediately before drying in the fixative solution (equal parts of 95% alcohol and ether). The clinician's method of obtaining the specimen is more important than the staining technique of the laboratory. The following check list may serve as a guide:

1. Instruction of patient to avoid douching and intercourse for 24 hours.
2. Avoid vaginal examination before taking smears.
3. Avoid using lubricant in vagina. (may wet speculum with water).
4. Equipment and materials should be prepared and at hand.
5. Make smears reasonably abundant but thin and covering most of slide.
6. Immediate fixation — allow at least one hour for fixation.
7. Do not mail slides in fixative solution.
8. Properly label slides and supply pertinent clinical data.

It is the duty of the clinician to supply adequate clinical data to the cytologist. Some of the main pitfalls leading to false positive interpretations are in cellular changes associated with pregnancy, trichomonas infections, irradiation therapy and estrogen administration. Therefore, it is important to include any known pertinent data referable to these conditions or any other significant history which will aid the cytologist in arriving at a correct interpretation.

If smears are to be mailed they can be air dried after fixation, or kept moist by placing one drop of glycerin between the slides. They should them be properly wrapped to avoid breakage and mailed in a standard mailing tube.

II. *How Are Cytologic Smears Interpreted And What Do The Reports Mean to The Clinician?* It is essential that there be a clear under-

Presented before the Section on Obstetrics and Gynecology, 114th Annual Meeting, Illinois State Medical Society, Chicago, May 18, 1954.

From Dept. of Pathology, Grant Hospital, Chicago, Ill.

standing between the clinician and cytologist as to the method of reporting. In general, most smears can be classified as negative, doubtful or positive. The method of Papanicolaou is frequently used and we use this system of reporting in our laboratory. This system of classification is as follows:

METHOD OF REPORTING CYTOLOGIC SMEAR INTERPRETATIONS

CLASS I. Negative
Normal cellular elements.
No atypical cells.

CLASS II. Negative
Atypical cells present which may indicate a benign lesion such as infection, metaplasia, polyps, etc.
No evidence of malignancy.

CLASS III. Suspicious
Abnormal cells, possibility of malignant origin. Insufficient criteria for positive identification.
Repeat smears indicated.

CLASS IV. Positive
Abnormal cells present indicating malignancy.
Evidence fairly conclusive.
Biopsy indicated.

CLASS V. Positive
Many abnormal cells showing all the criteria for malignancy,
Confirm by biopsy.

A. *NEGATIVE SMEARS*: It is hard to evaluate the true incidence of false negative smears because of the difficulty of follow-up studies. The known overall percentage has varied from 0 to 1.2% in different series. However, if only proven positive cases are considered, the occurrence of false negative smears among such a series may vary from 10 to 30%. Negative smears should never be relied upon to rule out carcinoma, when clinical suspicion exists. A biopsy should always be performed when there are clinical indications, even when negative smears are obtained. Negative smears are sometimes obtained when there is a clinically obvious cancer due to absent or intermittent exfoliation, or due to destruction of exfoliated cells as a result of ulceration and infection. The incidence of negative smears in known cases of endometrial carcinoma is at least 20 to 25%. Therefore, never rely upon smears to rule out carcinoma in a case of postmenopausal bleeding. The facts above indicate that cytologic methods should never replace biopsy studies, when indicated.

B. *SUSPICIOUS SMEARS*: Approximately 50% of patients with suspicious smears prove to have carcinoma, while the other 50% have benign lesions. In the presence of suspicious smears every effort should be made to locate and prove a malignant lesion by physical examination and biopsy studies. If no lesion is present, smears should be repeated for verification. Personal consultation between the clinician, cytologist and pathologist is the best procedure in attempting to solve doubtful cases.

C. *POSITIVE SMEARS*: Positive smears must always be confirmed by biopsy and histopathologic diagnosis before therapy is instituted. There are three main reasons for this statement: 1) the inherent percentage of error in the smear; 2) failure to localize the tumor; 3) failure to accurately determine the type and invasive qualities of the tumor. While the overall accuracy of positive smears ranges from 95 to 98%, these figures are deceiving when large numbers of negative smears are included in a group. A better evaluation of the accuracy is obtained when false positive reports are compared only with the proven positive reports. When this is done the percentage of false positives compared to proven positives ranges from 8 to 25% with an average of 16%. One can readily conclude that this is much too high a percentage of positive diagnostic error to be accepted as a sole basis for definitive radical treatment. The physician who proceeds soley on smear interpretations leaves himself wide open for criticism. Positive smears have been found occasionally when the tumor is outside of the uterus such as in the vagina, Fallopian tube, ovaries, and even the urinary bladder. Positive smears are produced by carcinoma in situ. The type of treatment may depend upon the type or invasive quality of a tumor which can only be determined by histo-pathologic studies. The chief value of the positive smear lies in its ability to detect cancer before symptoms occur and before a lesion is clinically evident. It can be very helpful in supplementing a biopsy in case the neoplastic area is missed.

III. *How Should Cytology Be Used In Practice?* The use of cytologic methods in practice depends upon three main advantages: 1) its ability to detect incipient carcinoma before symptoms or physical findings appear; 2) a more adequate sampling of the entire epithelial surface of the cervix when compared to the focal sample obtained by a single biopsy; 3) the simplicity of obtaining specimens.

A. *USE IN SCREENING*: The universal use of cytology for cancer detection among asymptomatic women in a given population group is open to controversy because of two reasons: economic considerations and the shortage of trained technicians and cytologists to do the work. If the present assumptions concerning carcinoma in situ are correct, then routine cytologic screening of women over 30 years of age at 6 to 12 month intervals could, theoretically, almost eliminate invasive carcinoma of the cervix. However, routine cytologic screening should be tempered by economic and practical considerations. Certain population groups may not be productive of very many cancers in relation to the cost. It should be used as a part of most routine gynecologic physical examinations and in certain special investigations. We must be aware that cytology or any other laboratory procedure is not an adequate substitute for careful pelvic examination in any cancer detection program.

B. *COMBINED WITH BIOPSY*: Since biopsy frequently will miss early lesions, the combined use of smear and biopsy will detect more cancers than either method alone. From a scientific viewpoint, correlation of the results of smear and biopsy studies affords valuable data for future reference. This may be of practical importance in furthering our knowledge of the natural history of uterine carcinoma.

C. *PRE-OPERATIVE STUDY*: Smears should not be used to replace biopsy or curettage, when these diagnostic methods are indicated. However, when these procedures are omitted in the presence of lesions considered to be clinically benign, negative smears add reassurance to the clinical evaluation. On the other hand, positive cytologic smears may prevent an inadequate procedure, such as a supracervical hysterectomy for fibroids, when an unsuspected cervical cancer exists. It may reveal a hidden endometrial cancer in a fibroid uterus. Cauterization of the cervix should not be performed until after cytologic smears have been reported. If a smear is reported positive after cauterization has been done, then the chance for immediate histologic confirmation of an early carcinoma may have been lost.

D. *POST-OPERATIVE OR POST-IRRADIATION FOLLOW-UP STUDIES*: Cytologic smears are being used with some success in judging the effectiveness of radiation therapy. This use is rather limited at present and additional knowledge of this application is needed. However, smears do afford a valuable and simple method for detection of recurrences.

IV. *The Problem Of Carcinoma In Situ Of The Cervix Uteri.* Because of the effectiveness of cytologic smears in detecting early cervical cancers, the histopathologic diagnosis of carcinoma in situ is being made with increasing frequency. This has raised many questions regarding the diagnosis, prognosis and treatment of this entity. Carcinoma in situ may be defined as a process involving the surface epithelium or underlying gland spaces by an abnormal epithelial growth, the cells of which are morphologically identical to those seen in cancer, but stromal invasion is lacking. There is considerable difference of opinion among pathologists regarding terminology, related epithelial changes and histologic criteria, but this is another broad subject beyond the scope of this discussion. Present evidence indicates that this lesion has existed prior to invasive carcinoma in a high percentage of cases and that it precedes the development of invasive carcinoma by some 5 to 8 years. We do not know whether the lesion may be reversible, if left undisturbed, or what percentage of cases of carcinoma in situ progress to invasive cancer. If the lesion is really "in situ" then it is not a clinical cancer in our usual definition of the term. The practicing physician must be aware that this condition is much different than true invasive carcinoma from the standpoint of prognosis and treatment. It occurs frequently during the child bearing age of 30 to 40 (an age 5 to 10 years younger than the incidence of invasive carcinoma). It is associated with initial positive cytologic smears in approximately 80% of the cases. Thus positive smears do not usually distinguish between carcinoma in situ and inva-

sive carcinoma. This fact re-emphasizes the need for confirmatory biopsies in order to be sure of the type of lesion one is treating. A random biopsy will miss a high percentage of these lesions, since it is frequently a focal process. Carcinoma is situ is a histologic diagnosis since it produces no symptoms and most cases have no gross lesions that can be associated with the condition. Since this lesion may co-exist with invasive carcinoma we cannot apply the diagnosis to a patient unless the entire cervix is available for study. A diagnosis of carcinoma in situ in one or several biopsy specimens does not rule out a co-existing invasive carcinoma in some other area of the cervix. A cone biopsy followed by serial block studies of the entire cervix is the only method of being reasonably sure of the diagnosis. Serial block study does not mean serial sections, which would be entirely impractical, but means study of one or more sections from 8 to 15 blocks of tissue representing the entire circumference of the cervical os. Preferably, the cone biopsy should be done with a knife and before dilitation of the cervix in order to preserve the epithelial surface and obtain the best possible material for histologic study.

V. *What Procedure Should Be Followed For Detection And Confirmation of early cervical carcinoma?* We have two methods available for a presumptive diagnosis of early cervical cancer. These methods are cytologic smears and random biopsy specimens. We must not rely *solely* on positive cytologic reports since the percentage of false positives is too high. Also, we must remember that we may be dealing with a carcinoma in situ. Random biopsy specimens may be used on a normal cervix or on an eroded cervix with no definite lesion. With no lesion present random biopsies may be taken from four quadrants. The deficiency of the biopsy is that it may miss a lesion or not show an area of invasion. In the presence of positive smear reports we must follow two separate lines of procedure depending on whether or not the cervix is normal in appearance or whether there is a cervical lesion. In the presence of a normal appearing cervix, repeat smears should be done for confirmation. If these repeat smears are positive, then the only sure method of diagnosis is circumferential or cone biopsy plus endocervical currettage. In the presence of a cervix with a lesion then we may biopsy this lesion. If the report from this lesion is carcinoma in situ then we should try to prove whether it is an invasive carcinoma by a cone biopsy (which is preferable) or by re-biopsy. This should be done because carcinoma in situ is not a valid diagnosis in a single biopsy specimen. It is justified only when the full distribution of the process is known within the limits of practicality.

SUMMARY

Cytology should be regarded as a detection method rather than a diagnostic procedure. It is a better detection method than biopsy, within certain limitations. It is not as accurate a method as biopsy for positive diagnosis. It does provide a simple method for more adequate sampling than a single biopsy. The smear is very useful in the earliest stages of malignancy. The combined use of cytology for detection and biopsy for confirmation is the ideal procedure to follow. A realistic appraisal of the shortcomings and limitations of both methods will benefit patients through earlier diagnosis and protecting them against therapy that may be either inadequate or too expensive.

551 West Grant Place,

BIBLIOGRAPHY

1. Achenbach, R. R. Johnstone, R. E. and Hertig, A. T.; The validity of vaginal smear diagnosis in carcinoma in situ of the cervix. Am. J. Obst. & Gynec. **61**:358-392, 1951.
2. Carter, B.; Cuyler, K. Thomas, W. L.; Creadick, R., and Alter, R.; The methods of management of carcinoma in situ of the cervix. Am. J. Obst. & Gynec. **64**:833-845; disc. 845-849, 1952.
3. Cuyler, W. K.; Kaufmann, L. A.; Carter, B.; Ross, R. A.; Thomas, W. L. and Palumbo, L.; Genital cytology in obstetric and gynecologic patients. A four-year study. Am. J. Obst. & Gynec. **62**:262-275; Disc. 275-278, 1951.
4. Ferguson, J. H., Some limitations of cytological diagnosis of malignant tumor. Cancer, 2:845-852, 1949.
5. Galvin, G. A.; Jones, H. W., Jr., and TeLinde, R. W.; Clinical relationship of carcinoma in situ and invasive carcinoma of the cervix. J.A.M.A. **149**:744-748, 1952.
6. Gusberg, S. B.: Coning biopsy in the detection of early cancer of the cervix; a survey of 500 normal women. Am. J. Obst. & Gynec. **61**:276-288, 1951.
7. Hertig, A. T., and Younge, P. A.; What is cancer in situ of the cervix? Is it the preinvasive form of true cancer? Am. J. Obst. & Gynec. **64**:807-815; disc. 825-832, 1952.
8. McKelvey, J.L.; Carcinoma in situ of the cervix; a general consideration. Am. J. Obst. & Gynec. **64**:816-825; disc. 825-832, 1952.
9. Nieburghs, H. E., and Pund, E. R.: Detection of cancer of the cervix uteri; evaluation of comparative exfoliative cytologic diagnosis: study of 10,000 cases. J.A.M.A. **142**:221-225; disc. 225-226, 1950.
10. Reagan, J. W. and Schmidt, R. T. Evaluation of cytologi-

cal technic in recognition of malignant neoplasm. J.A.M.A. **145**:82-85; 1951.
11. Reagan, J. W. and Hicks, Dorothy J.: A study of in situ and squamous cell cancer of the uterine cervix. Cancer: Vol. 6, Number 6, 1200-1214, 1953.
12. Scapier, J.; Day, E., and Durfee, G. R.: Intraepithelial carcinoma of the cervix. a cytohistological and clinical study. Cancer **5**:315-323, 1952.
13. Younge, P. A.; Hertig, A. T., and Armstrong, D.: A study of 135 cases of carcinoma in situ of the cervix at the Free Hospital for Women. Am. J. Obst. & Gynec. **58**:867-892; disc. 892-895, 1949.

‹‹‹ ›››

An Introduction to the INDUSTRIAL NOISE PROBLEM

Aram Glorig, M.D.* and Douglas E. Wheeler, Ph.D.†, Los Angeles, California

THE ear, its nerve tracts and physiological processes are an extremely complex mechanism. The external and middle ears are relatively well understood, but the inner ear, and especially the organ of Corti, is still pretty much a mystery. Recent advances in electronic instrument design have made it possible to approach the problem in a much more satisfactory manner, and obtain a great deal more information about the function of the inner ear.

In general, the young human ear can distinguish frequencies between 20 and 20,000 cycles per second. The frequencies important for speech intelligibility are contained between 300 and 3000 cycles per second. The speech area is further divided into the vowel and consonant frequencies. The vowel frequencies lie between 300 and 1500, and the consonant frequencies are within 1500 and 3000. Therefore, in testing the function of the ear for speech, two word lists are used—a so-called "spondee" list for vowels and a "PB or phonetically balanced" list for the consonants. These two lists test respectively the "speech reception threshold" or determine the amount of volume needed before speech is heard, and "discrimination" or the ability of the ear to recognize the speech sounds well enough to repeat them. Most pure tone audiometers test between 125 and 8000 cycles per second at octave steps—i.e., 125, 250, 500, 1000, 2000, 4000, 8000.

The ear is most sensitive to acoustic energy in the frequency rangion of 1000 — 4000 cycles and is less sensitive as frequency is decreased below or increased above this region.

Measurements of hearing are referred to "average normal hearing," corresponding to zero on the audiometer scale and since these measurements are expressed in terms of "decibels of hearing loss" zero would mean no loss and any increase in output necessary to reach threshold would be a hearing loss of so many decibels. See Figure 1.

The decibel or "db" is a unit of measurement related to sound energy. It is based on a logarithmic scale to the base 10. This means that 20 db has 10 times the energy of 10 db, and 100 db would be equal to 1,000,000,000 (one billion) times the energy of 10 db.

If the ear were more sensitive one could hear the air molecules bumping around in the external auditory canal. We know the drumhead moves about one tenth the diameter of a hydrogen molecule when stimulated at threshold. Is it any wonder that this delicate mechanism

***Director of Research, Subcommittee on Noise in Industry.**

†Field Representative, Subcommittee on Noise in Industry.

Portions of this paper have appeared in the American Industrial Hygiene Quarterly, Vol. 14:3, 1953.

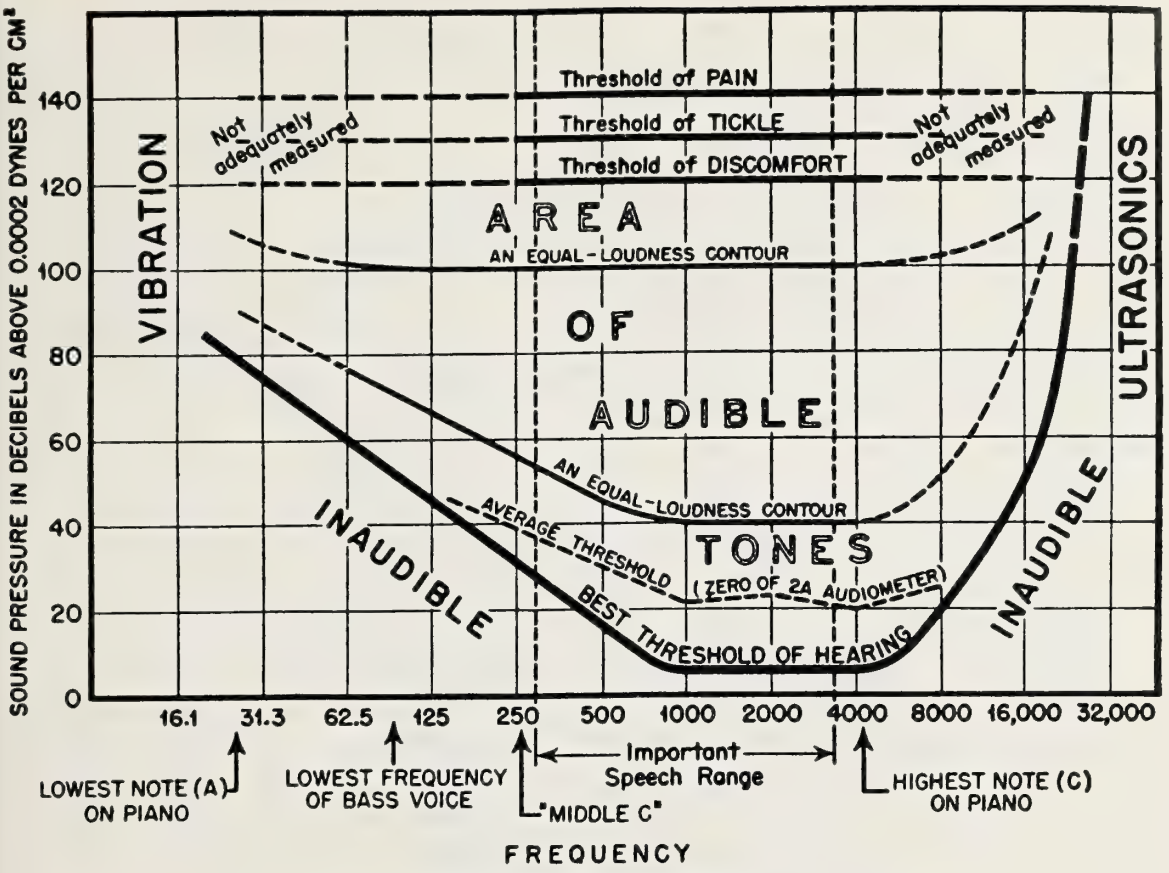


Figure 1. The Auditory Field.

may suffer injury when exposed to many billion times this amount of energy for any length of time?

NOISE

We have discussed the ear briefly; now let us consider the problem of the "noise." First, how is noise defined? Simply, it is "any unwanted sound." For example, the last speaker on a long program; the yowl of cats at midnight; a cough during a concert or play; and any one of a dozen other examples.

Noise, like any other sound, is measured in two dimensions—intensity level and frequency. The unit of intensity level is the decibel, but in this case it is referred to a different reference level than average normal hearing. Sound produces pressure; a reference of 0.0002 dynes per square centimeter is the point at which the decibel scale begins when the sound pressure level is measured. The unit for measuring frequency is the cycle; however, noise is such a complex sound that it is usually measured frequency-wise in "octave bands", that is: 75-150, 150-300, 300-600 cycles per second, etc. (See Figure 2.)

The decibel meter, or sound level meter, is

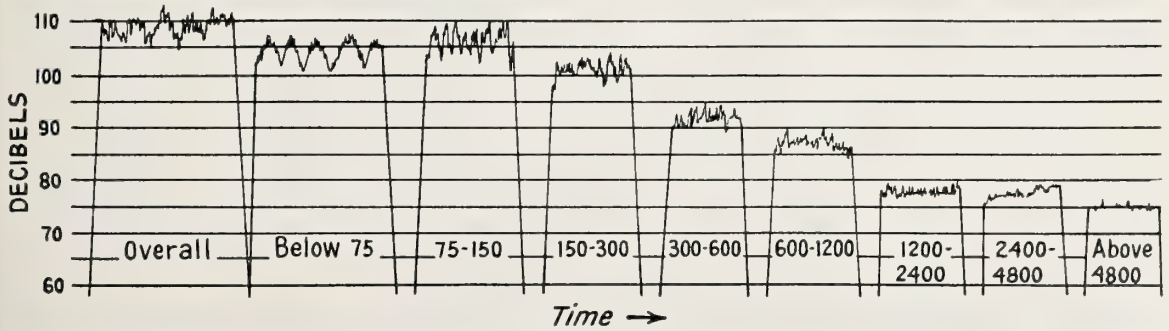
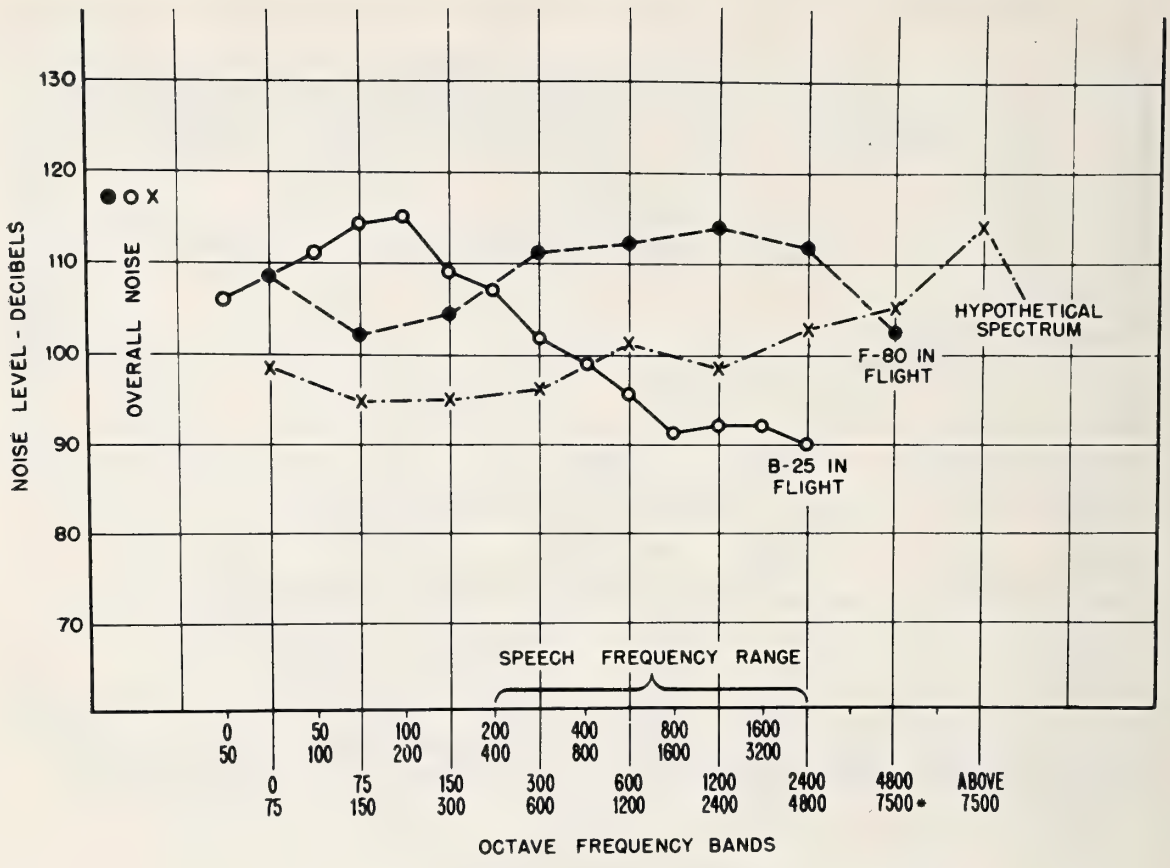


Figure 2. Frequency Analysis by Graphic Methods. Noise in multi-engine bomber, treated with absorbing material, analysis in octave bands.



* This point for the F-80 covers all frequencies above 4800 cps. For the hypothetical curve it represents only the energy in the band from 4800 to 7500 cps.

Figure 3. Frequency Analysis by Octave Band Analyzer.

the instrument used to measure intensity. It is a microphone with an amplifying unit and a meter based on the decibel scale. The db meter is adequate for noises of a more or less constant level and where the over-all noise level only is desired; however, for intermittent noises such as a punch press, a drop forge hammer, or a machine gun, the meter type instrument will measure only an average of the peaks that occur because of the inertial or latency of the meter. A specially calibrated oscilloscope is necessary for this type of measurement.

For octave band analysis work, the sound level meter or the oscilloscope is attached to a series of filters. This allows for checking the energy distribution as a function of frequency. (See Figure 3.)

Whenever noise measurements are considered, these two dimensions are mandatory.

Noise levels produced in general industry lie within the range 80 — 130 db. Jet engines may measure as high as 150 db. Sound pressure levels as high as 180 db are found with gun explosions. Gunfire sounds are instantaneous and are probably more damaging than continuous noise at lower sound pressure levels. The rise and fall time is less than 2 — 3 milliseconds. Little is known about the details of the effect of single peaks on the ear, but observation has demonstrated many hearing losses due to gunfire, particularly from small arms.

With increase in speed and power there is always an increase of noise. With the limits of speed and power nowhere in sight as yet, it appears that the human organism may be the limiting factor in man's attempt to mechanize himself. These dramatic developments are rightfully a matter of concern to all of us. The physician, however, should remind himself that the difficult problems in noise-induced hearing loss will most frequently be encountered in the area of general industry.

BIO-ACOUSTIC EFFECTS OF NOISE

Having learned something of the psycho-

physics of the ear, and the definition and dimensions of noise, we are ready to discuss some of the effects of noise on the human, with particular reference to the ear.

Much has been said and written concerning the effect of noise on the behavior of man. Some of these effects include nervousness, fatigue, inefficiency, sterility, and even death. There is no scientific evidence known to the writers which properly supports such claims, particularly the latter two.

The two important effects that can be supported with overwhelming evidence are interference with communication and the production of a hearing loss.

One merely needs to try to talk to his fellow worker in the presence of more than 90 db of noise to know the effect produced on communication. This phenomenon has been quite thoroughly studied and one can predict what the intelligibility of speech will be in the presence of specified amounts of noise.

The studies show also that, as noise levels are increased, the output power of the human larynx becomes unsufficient to over-ride the noise and communication by voice cannot be accomplished. Many common industrial processes produce such noise levels. While men are working in uninterrupted high level noise, their hearing for voice signals is not useful, even though no pathology is present.

There is no doubt that pathological hearing loss may be the result of industrial noise exposure. Before a discussion of some evidence, however, it must be mentioned that presbycusis (loss of acuity with increasing chronological age) is also a factor. In general, this type of loss cannot easily be distinguished from noise-induced hearing loss. Figure 4, shows the magnitude of losses due to presbycusis which may be expected in the general population. The data were collected in several large sample studies, such as those conducted at the World's Fair and the San Diego County Fair.

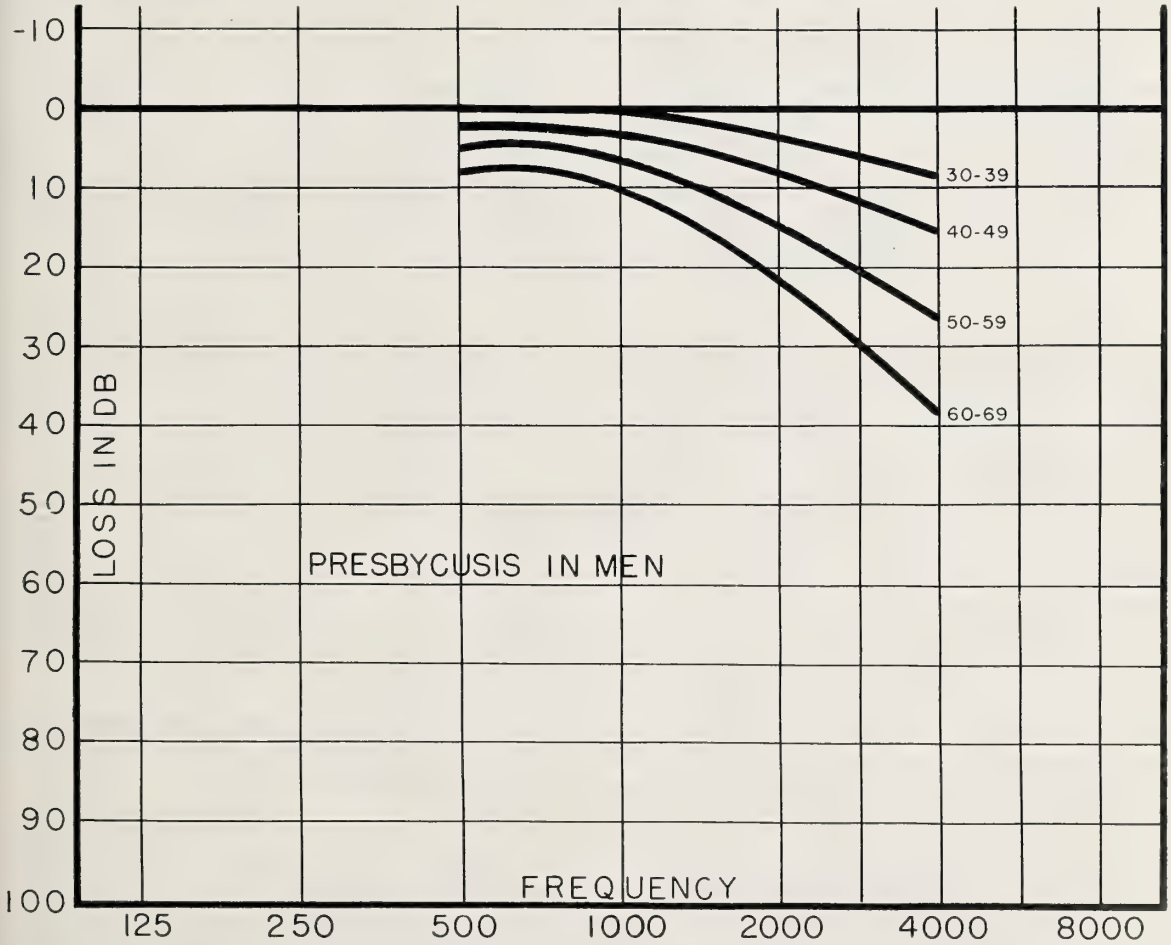


Figure 4. Effects of Increasing Chronological Age.

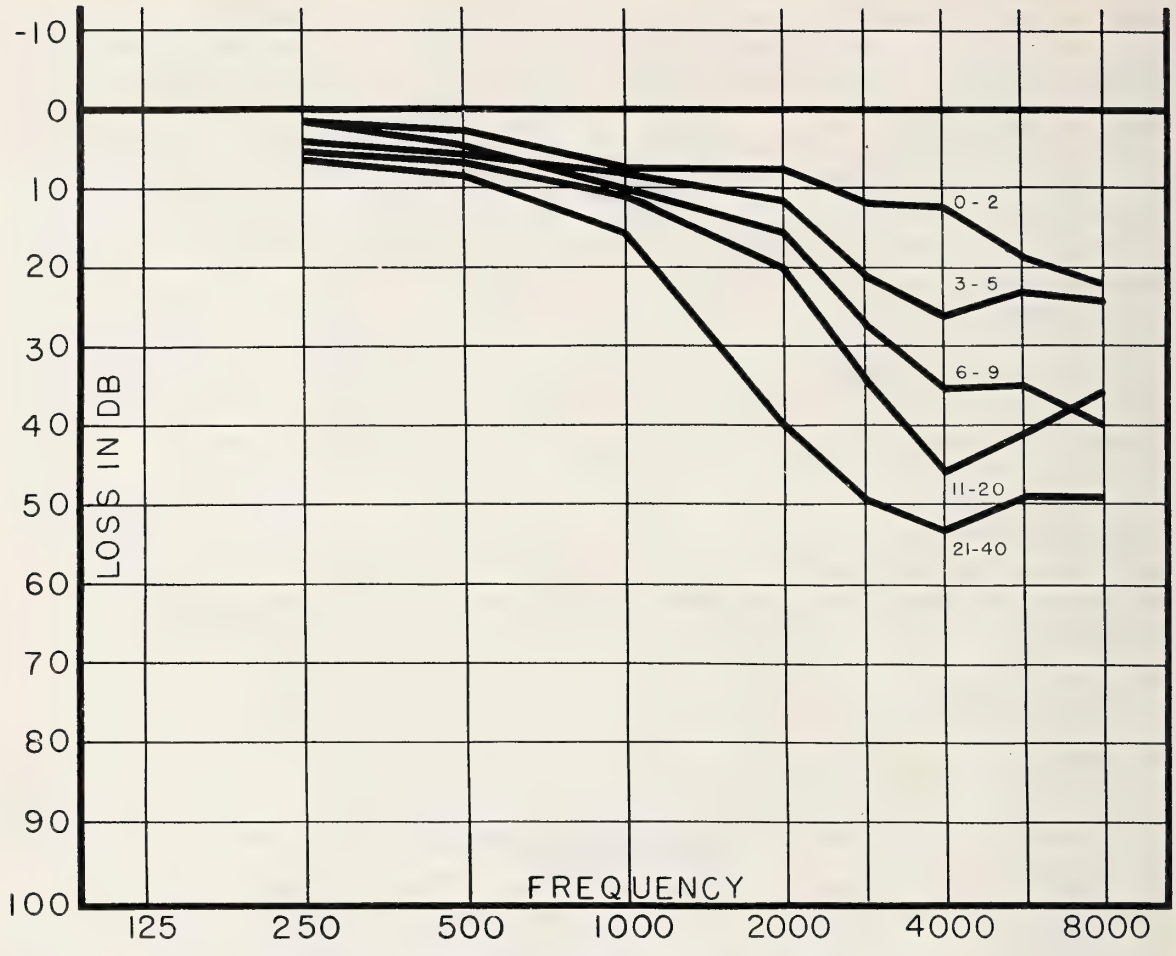


Figure 5. Mean Losses of Men Working for the Years Shown in a Constant Flat Spectrum Noise Level of 105 db.

Because a man who has worked for many years under noise exposure must also be a man whose age is increasing, it is clear that presbycusis becomes significant in the later decades. Inspection of Figure 5, however, will show that the hearing losses found in one study considerably exceed the losses to be expected from presbycusis alone; these results are supported by other studies.

It is certain that hearing loss is produced by noise, but there are many questions concerning this left unanswered at present. Some of these are:

1. How much noise is necessary?
2. What frequencies or frequency ranges are most important?
3. What is the effect of individual susceptibility on the overall problem?
4. How can we predetermine who is more susceptible?
5. How much exposure time is necessary?
6. When can the hearing loss be said to be permanent?
7. Is such a hearing loss progressive after removal from the noisy environment?

These are just a few of the multitude of questions to be answered by future research under controlled field conditions. This cannot be done, however, without the cooperation of industry over a period of not less than three to five years. Such questions can only be partly answered in the laboratory.

HEARING CONSERVATION

Until these answers are obtained industry must proceed along these lines:

1. All routine preplacement physical examinations must include air conduction threshold audiometry.

2. All individuals working in noisy areas suspected of having produced a hearing loss,

whether temporary or permanent, should be followed with hearing checks every 6-12 months.

3. All suspected areas should be studied for possible noise reduction procedures.

4. Educational programs regarding ear protectors must be instituted.

Preplacement audiograms are necessary to protect both the employer and the employee. They establish the individual hearing baseline for future reference purposes—for example, to follow changes in hearing produced by the environment, and to establish any preplacement hearing loss. Surveys in certain industries have shown that about 25% of applicants have a significant hearing loss.

Reduction of noise at the source should be attempted in all noisy areas. Such reduction can be done by enclosures, sound treating with absorbing material, or changes in machine design or mounting or both.

Ear protectors are a must in noisy areas. There are several presently available which are adequate for ordinary industrial noises. It should be the business of every hygienist and safety engineer to propagandize the use of ear protectors. The best ear protector is the one that is worn. Further research will probably produce more effective and more comfortable ear plugs. In the meantime every effort should be made to conserve hearing by example, education, and regulation. Many are against ear plugs because, they claim, when ear plugs are worn, communication by spoken voice is impossible and warning signals are not heard. This assumption is fallacious. As a matter of fact, communication in noise is improved when ear plugs are worn. This is easy to demonstrate. Merely put your fingers in your ears while conversing in a noisy area; you will immediately notice that conversation can be heard as well as, and possible better than, with the ears unoccluded. The same is true of warning signals.

Questions about ear protectors should be addressed to the Counsil on Physical Medicine and Rehabilitation of the American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois.

EQUIPMENT AND TEST ENVIRONMENT

Instruments for measuring hearing may be divided into pure tone and speech audiometers. The pure tone instruments are called screening and diagnostic audiometers. Speech audiometers are just becoming available and at present are based on disc recordings or monitored so-called "live voice".

There are several makes of sound level meters and sound analyzers that meet the specifications of the American Standards Association.

Prices on these types of equipment vary between $300.00 and $1000.00.

All hearing tests should be done in a quiet room. Accomplishing this is sometimes difficult because of the location. A simple procedure is to locate an area where the ambient noise is low and yet relatively easily accessible. This should be away from elevators, water or steam pipes, outside walls where traffic noises abound, and noisy corridors. When a suitable location is found a double room about 8 x 8 x 7.6 high (inside measurements) should be built. As far as possible this should be a cubicle within a cubicle with *no* connections between the walls and as few supports between floors as possible. These should be rubber or felt blocks similar to hockey pucks or felt engine mounts.

ACTIVITIES IN THE FIELD

Because certain questions were left unanswered and the need for research on these questions was clearly indicated in a previous section of this discussion, the physician may properly ask how and by whom this research will be carried out.

The Subcommittee on Noise in Industry of the Committee on Conservation of Hearing of the American Academy of Ophthalmology and Otolaryngology has been active since 1946. In 1949 this subcommittee hired a field representative to study the problem in the field and laboratory. Since then a great deal of groundwork has been laid and access to industry (at first difficult) is becoming easier. Certain aspects of the Subcommittee's research involve cooperation with the American Medical Association.

Recently the Armed Forces and the National Research Council combined to form a committee on Hearing and Bio-Acoustics. This committee will guide the Armed Forces in the many ramifications concerning noise.

The American Standards Association, sponsored by the Acoustical Society of America, has a committee called Z-24-X-2, or the Com-

mittee on Bio and Psycho-Acoustic Criteria. This committee has recently published a study entitled "The Relations of Hearing Loss to Noise Exposure".

In the past, the only information available on the subject of noise-induced hearing loss came from the reports of interested physicians. The clinical experience and judgment of the physician were, and still are, extremely important; the physician is the final authority in questions about hearing loss of whatever etiology. This position, however, imposes an obligation. The physician must know the facts concerning industrial noise exposure. A simple statement by the patient that he works in "noise" can no longer be accepted as prima facie evidence that the hearing loss disclosed has an industrial origin. The physician, particularly when involved at the medico-legal level, must know how much noise, of what type and characteristics, for how long; he may anticipate being confronted with these questions by counsel.

SUMMARY

1. The psycho-physics of the ear in relation to noise are presented briefly.

2. Noise is defined as any unwanted sound and should always be measured in two dimensions—intensity level and frequency.

3. The known effects of noise are in the main confined to those on communication and damage to the hearing mechanism.

4. Hearing conservation should be the guiding principle of the industrial physician, hygienist, and safety engineer where excessive noise is concerned.

5. The hearing loss produced by noise is an irreversible nerve type loss.

6. There is adequate equipment easily available for measuring hearing and noise.

7. The American Academy of Ophthalmology and Otolaryngology, and Armed Forces and National Research Council and the American Standards Association have organized very able and active committees to study their respective problems with noise.

111 N. Bonnie Brae St.

REFERENCES

1. Kryter, Karl D. "The Effects of Noise on Man", Monograph Supplement 1, J. Speech & Hearing Disorders, 1950.

2. Noise—Causes, Effects, Measurement, Costs, Control, the published proceedings of the Inservice Training Course on "The Acoustical Spectrum—Sound, Wanted and Unwanted", given by the School of Public Health and the Institute of Industrial Health, University of Michigan, Ann Arbor, February 5-8, 1952.

3. Proceedings of the Annual National Noise Abatement Symposium, Technology Center, Chicago, Illinois, 1950-51-52-53. Sponsored jointly by The Acoustical Society of America, The Acoustical Materials Association, The American Industrial Hygiene Association, The National Noise Abatement Council, and Armour Research Foundation of Illinois Institute of Technology.

4. Guides for Industry. Obtainable from Howard P. House, M.D., Chairman, Subcommittee on Noise in Industry of the Committee on Conservation of Hearing of the American Academy of Opthalmology and Otolaryngology, 1136 West Sixth Street, Los Angeles, California.

5. The Relations of Hearing Loss to Noise Exposure. Obtainable from American Standards Association, Inc., 70 E. 45th Street, New York City.

The text book in court

You may be asked whether you agree or disagree with certain statements appearing in recognized medical books and authorities, and for that purpose counsel may read to you excerpts from such books. These medical books are not admissible in evidence to establish the declarations or opinions which they contain (State vs. Baldwin, 36 Kan. 1). However, the Supreme Court said (Stout vs. Bowers, 97 Kan. 33, 36) : "One of the recognized methods of testing the knowledge of an expert witness who finds his opinions on standard medical authorities is to read from those authorities upon the subject in question and interrogate him as to whether his opinions coincide with those expressed in the books and whether there is not a conflict between the opinions he then gives and the views expressed by the authorities upon which he relies for information." *Joseph Cohen, The Doctor Goes to Court. J. Kansas M. Soc. July,* 1954.

An Evaluation of the Treatment of the Hemangioma

Albert H. Slepyan, M.D., Highland Park

IN reviewing the medical literature of today, it becomes apparent, that there is no uniformity of opinion as to the management of the vascular nevi. The pediatrician, the dermatologist, the radiologist, and the practitioner are often at variance as to the necessity for, or, the time of treatment to insure good cosmetic results. Some feel that for most lesions treatment is begun too early, and that for some, no treatment is indicated at all, and still others feel that the golden opportunity of time is missed in waiting. This difference of opinion is understandable when one realizes that each operator becomes adept with his own experiences, in his own specialty, and in turn relates these experiences, although limited, with enthusiasm bordering on finality.

In this short presentation I should like to take up the problem of the present day management of the vascular nevi. Treatment, without clear cut classification and understanding of the natural history of the lesion can only lead to misconception as to the efficacy of the method used. The aim of treatment is to produce the involution of the tumor with the least amount of destruction to the tissue with the best cosmetic results. Before the operator is in a position to render judgment as to the management of an individual lesion, he must acquaint himself with the clinical characteristics of this group of lesions and correlate them with their pathologic structure. He must further be aware of the natural history of the various types of hemangiomas just as the practitioner is aware of the usual sequence of events in a given medical disease.

Hemangiomata are now regarded as congenital malformations made up of ectopic rests of mesodermal vasoformative tissue. This tissue is at first solid and consists of endothelial cells similar to those which line blood vessels, interspersed with strands of connective tissue. Later these become canalized and differentiated. When canalization occurs recognizable arteries, veins, and capillaries appear. All three elements can be found in every lesion, but one usually predominates and gives the birthmark its characteristic clinical picture. If two are predominant in large amounts, the commonest combination is usually a mixture of cavernous and capillary tissue.

While all hemangiomata are basically the same in that they are derived from vasoformative tissue, it is not at all suprising that their clinical appearance are so diverse when one considers the variation in size, depth, site, rate of growth, and amount of canalization. Then too, when the pathologic accidents of ulceration, infection, infarction, thrombosis, sclerosis and fibrosis are added, each increases the list of clinical variables. (Table 1)

Flat Capillary Nevi. — Lesions that can be blanched on stretching, represent tumors superficially placed and often lighten or disappear more or less by the end of the second year. The neonatal stain or unnas nevus and the salmon patch type represent this group. The nevus flammeus cannot be blanched and will persist

TABLE 1
CLASSIFICATION OF COMMON HEMANGIOMA

Flat Nevi (Capillary)
Neonatal Stain — Nuchal and Gabellar
Salmon patch
Portwine stain — Nevus flammeus
Raised Nevi (Capillary)
1. Angioma Simplex — Strawberry and Raspberry
2. Hypertrophic Angioma Simplex
Cavernous Hemangioma
Mixed Types
Cirsoid or Racemose Hemangioma
Lymphangioma
1. Lymphangioma Circumscriptum
2. Cystic Hygroma

Assistant Professor of Dermatology, University of Illinois, Service Dr. F. E. Senear.

Presented at the Illinois State Medical Society Meeting, May 1953.

through life sometimes becoming a shade or two lighter thru infancy.

It is best with present day knowledge to do nothing with a portwine lesion that will produce an irregular or uneven surface. With some effect, we can direct the patient to use a cosmetic known as "Covermark" to hide the blemish. This preparation must be carefully blended to match the patient's skin. Smaller lesions if fortunately located can be excised surgically. Sand papering has been advocated but is applicable only in the more superficial lesions.

Tatooing as a means of camouflage with soluble pigments are being used but as yet not generally accepted. Grenz rays have been suggested as have Kromayer ultra violet light. The good results reported were in the superficial variety. These, because of their natural history often lighten spontaneously.

Radiation with radium or x-ray have not been effective and are contraindicated in the forms that we have available today.

Refrigeration with carbon dioxide therapy must be limited to the most superficial varieties, for in the deeper lesions it will only create mottling which accentuates the defects.

Raised Capillary Nevi. — The angioma simplex is characterized by being raised either bright red (strawberry mark) or dull purple red (the raspberry mark). These lesions are compressible with a glass slide. For the most part, an angioma simplex or angioma simplex hypertrophicus will disappear spontaneously within five years, leaving an excellent cosmetic result providing the lesion is under 2.5 cm. in diameter. The larger lesion commonly breaks down spontaneously and heals with irregular undesirable scarring. Lesions, therefore, treated lightly with carbon dioxide pencil at two to three weeks of age respond best. At the initial treatment, five seconds of moderately firm pressure is all that is used, so as to avoid too great an inflammatory reaction which might cause breakdown and scarring. Once involution is noted observation at regular intervals is all that is indicated. We have often noted new lesions appearing up to the age of six months, therefore, regular observation periods provide the means of checking and treating new lesions as they arise, early.

Angioma simplex hypertrophicus is a thickened angioma simplex. These lesions cannot be completely compressed with a glass slide. Their natural history is similar to that of the angioma simplex. It is, therefore, important to start the process of sclerosis and fibrosis, by one means or another, with early treatment. If the lesion is not too thickened or too large a five second application of carbon dioxide pencil with moderate pressure is the treatment of choice. X-ray therapy in dosages of 200r at intervals of one to three months is most effective if started in the first months of life. Recent reports of treatment with contact x-ray therapy in this group have been most gratifying.

Cavernous hemangiomata are characterized by being flat to raised bluish tumors which on palpation reveal the underlying vasoformative tissue that imparts the feeling of rubber bands in a plastic bag. The color, as a rule, cannot be compressed. In general, cavernous hemangiomata that show early growth and then become static do tend to involute spontaneously. Lesions, particularly about the head may begin to grow even after the sixth month. All cavernous hemangiomata should be watched closely for the first 18 months of life. There is no universal treatment for cavernous hemangiomata; each lesion must be evaluated individually, the site, depth, and rate of growth must be considered.

For lesions about the mucous membranes of the eyes, mouth, and anogenital area, and over epiphyseal areas, sclerosing solutions have been found easiest to use. Of the many solutions tried, quinine and urethane hydrochloride has proven to give the most constantly good results. When injecting the lesion the infant must be firmly and securely cradled by a competent assistant. The tumor is squeezed between the fingers as firmly as possible, and the substance injected at the base of the lesion. This pressure is held for a minute or two to allow contact of the solution with the tissue. Every effort is made to avoid superficial blanching of the tissue which could mean sloughing. Injections are given at no less than monthly intervals beginning with a small dose of .1 cc. up to 2 cc. at a treatment. In larger lesions several areas may be treated at one time. Often a solid nodule is created in the tumor that may persist for two to three months. It is well to wait for these nodules to resolve for with their absorption fibrosis and shrinkage takes place.

Elsewhere on the body, x-ray therapy can be used easily if the lesion is treated early within the first few weeks of life. Statistics reveal and our impression confirms that radiation is effective in direct relation to the age of the patient. The younger the patient the more radiosensitive the tumor. Doses of 200r, unfiltered low voltage x-ray are used. The patient is watched and further treatment is given only if the lesion appears not to be involuting. Re-treatment at three month intervals is given. If some involution is not apparent after two exposures, sclerosing solution is then started.

At times one is able to recognize the efferant and afferant vessels to the tumor. A small incision into the skin and tieing off of these feeder vessels followed by a sclerosing solution often hastens the involution of the lesion.

Complete surgical excision when good closure can be obtained is often satisfactory.

There are many who have learned to use radium well. Once again, selecting the proper filtration and dosage and using the smallest amount that will begin the process of fibrosis in the lesion is all that is desired in the use of radium. As long as the lesions show signs of involution watchful expectancy should be practiced.

When the lesions are of the mixed type as they commonly are, attention is directed to the underlying deep cavernous portion. The superficial portion can be treated as an angioma simplex at observation periods when the deeper portion is not being touched. The cirsoid or racemose hemangioma are characterized by a pulsating mass beneath the skin. This type of lesion is best treated by surgery.

In the group of lesions classified as lymphangiomas, the cystic hygroma is best excised with plastic repair. The more superficial variety, the lymphangioma circumscriptum often appears thru childhood. It is characterized by superficially placed pinhead-sized grouped papules that are traversed with fine telangiectatic vessels, that gives the lesion the appearance of fresh fish or frog spawn. At times the lesion suggests a patch of radio dermatitis. Pricking an isolated papule with a fine point will cause lymph to flow. Often times a few small fractional doses of low voltage x-ray therapy will cause these lesions to involute. For those radio resistant, light electrodesiccation is easily accomplished under local anesthesia. Carbon dioxide pencil has worked well in the hands of many dermatologists.

In summary, the portwine nevus is at best left alone. The neomatal stain may lighten or disappear spontaneously by the second year, while the salmon patch may or may not become lighter. The angioma simplex and the angioma simplex hypertrophicus and cavernous hemangioma are capable of sudden growth. These hemangiomas should be treated within the first few weeks of the infant's life, and observed from thereon with periodic regularity, remembering the natural tendencies of each type of lesion. It is better to start the process of fibrosis and observe and control the involution of the lesion rather than to have to correct the defect at a later date. Rapid growing lesions are immediate problems ities such as radiation, surgery, sclerosing or which involve the use of all the various modalcarbon dioxide therapy.

« « « » » »

The Physician, The Patient, and CANCER

Marc H. Hollender, M.D., Chicago

SEMINAR
of the Department of Medicine of the University of Illinois
Edited by:
Dr. Max Samter
Associate Professor of Medicine
Dr. Alexander Remenchik
Clinical Instructor in Medicine

Dr. Max Samter (Associate Professor of Medicine)

The question of the patient who faces the loss of an eye, of a limb, or who faces death, is as old as medicine itself. Throughout the ages, its moral and practical implications have stimulated violent arguments between physicians, writers, philosphers, and clergymen. The moral answers have varied from one extreme: that the truth must be told at all cost, to other: that the truth must never be told. The practical answer is more often than not a compromise: "It depends", someone will say, "on his family, and on his state and station in life." Unless the relationship between physician and patient is unusually close, it depends, in most instances, on a, perhaps, inspired guess rather than on a rational analysis of the forces which the truth will set in motion.

We are very grateful that Dr. Hollender has accepted our invitation to first outline the patients' response to mutilating illness, and second to discuss several of the problems which have been encountered by our resident staff in recent months.

Dr. Marc H. Hollender (Associate Professor of Psychiatry)

What will the loss of an organ mean to the patient? Attempts to answer this question simply on the basis of 1) the patient's general stability and 2) the type and degree of functional impairment involved have not proven satisfactory. To prognosticate in a more scientific way, a number of other factors should be considered. Among these are: 1) the *Specific Effect* of the loss (does it play into an unresolved conflict?), 2) the *Indirect Effect* (does it interfere with a pattern of adjustment that has been important in maintaining an emotional balance?), 3) *the Symbolic Effect* (what is the meaning of the loss in terms of the symbolic value of the organ?), the distortions in the *Body Image* (how prominent is the organ in the body image?).

SPECIFIC EFFECTS: Even the most stable person has emotional weak spots, and if the loss of an organ touches upon one of these areas, a serious emotional upheaval may result. To illustrate: A reasonable stable man had a latent but intense conflict about his soiling impulses. A colostomy, with its attendant dangers of soiling in spite of irrigations and rigid dietary limitations, reactivated his old anxieties. It is conceivable—and even likely—that this patient could have had an amputation or a laryngectomy without a marked psychological reaction. Thus it is necessary to know the vulnerable areas in a "generally stable person" to be able to predict the response to the loss of a bodily part.

Sutherland points out that under certain circumstances a grossly disturbed patient may weather multilating surgery without serious emotional difficulties. "A schizophrenic boy who underwent an amputation of the arm and shoulder for a bone tumor had little trouble in accepting this disability because it remained peripheral to his central problems of his own sexuality and his mother." Thus an operation which does not impinge on a vulnerable area may not cause an upheaval even in a disturbed person.

INDIRECT EFFECT: A stress may exert a profound effect when it blocks an avenue of expression that has been important in an individual's emotional adjustment. For example, when the loss of an organ makes it impossible for a work-geared man to continue at his occupation, the reaction may be marked. In this instance the stress interferes with an activity which, in addition to its realistic significance, had been a prop supporting a shaky psychological balance.

On the other hand, when a person strongly desires to lie back and be cared for, the loss of an organ may foster a retreat to a stage of helpless dependency. This was the case when a 68 year old woman had a breast removed. She had worked "with a will" from the age of eight years, when she began to help her sickly mother with household chores and the care of two younger brothers. In her adult years, she had nursed her mother and later her husband. When they died, she took a position as a companion and remained at that job until it became necessary for her to have a breast operation. From that time on, she felt that she could no longer work, and she entered a home for the aged.

The patient's dependent wishes had been covered over by doing things for others. At the same time she derived some gratification of her own longings by identifying with the people she nursed. When she could use illness as a justification for her demands, her dependent cravings were expressed directly. In this instance, illness fostered the break-through of intense, latent desires and resulted in a marked regression.

SYMBOLIC EFFECT: Some paradoxical reactions to the loss of an organ can be understood when we recognize that the symbolic meaning of a bodily part may be more important psychologically than its utilitarian function. Thus a school teacher who reacts to an amputation as a castrative-type of mutilation may be more upset than a lumberjack who does not.

In discussing carcinoma of the breast, Renneker and Cutler state: "The breast . . . . . is the emotional symbol of the woman's pride in her sexuality and in her motherliness." As a result, a mastectomy is a serious threat to a woman's femininity. This is true in a woman of 60 as well as one of 40. The less secure a woman is in her feelings of femininity, the more endangered will she be.

The symbolic significance of an organ, whether culturally or individually determined, should be weighed carefully in predicting the reaction to its removal.

DISTORTIONS IN THE BODY IMAGE: The body image is a person's picture of his physical self. Various distortions may occur as the result of early conditioning experiences and occasionally these may be responsible for unusual reactions to the loss of an organ. This is illustrated by the case of a 70 year old woman who had a mild reaction to the loss of a breast but an extremely severe one to a successful cataract operation. Four years after an uneventful recovery from a radical mastectomy, she was told that she required eye surgery. She broke down in the doctor's office and cried bitterly. She said that this was very unlike her because, although she occasionally cried, she had never broken down before in public. After the surgery, she went into a serious depression for which she was hospitalized for more than a month. Even two years later, she would not go to a physician to have her other eye checked for fear that surgery would be advised. In speaking of this she said that she would rather have a limb amputated than let anyone touch her eyes. In discussing her early life, she spontaneously related that as a child she had been much less attractive than an older brother. Her beautiful eyes were her one redeeming feature and they were often the subject of complimentary remarks. Apparently as a result of these early experiences her body image was distorted in such a way that her eyes occupied a huge part of it. An analogy can be drawn to the humorous version of the Texan's map of the United States in which the other 47 states form a small rim on three sides of Texas,

The factors which have been discussed are important in *dealing with* as well as anticipating reactions to the loss of an organ. To enlarge upon this, each group will be considered briefly.
SPECIFIC EFFECT: When the stress strikes a weak spot, you may be able to foster the re-establishment of a balance by encouraging the patient to ventilate and by helping him

to understand his feelings. In some instances psychiatric treatment will be necessary. *INDIRECT EFFECT*: If the removal of an organ threatens to interfere with an occupation that has been important in maintaining an emotional balance, it may be of benefit to discuss the real limitations and perhaps to suggest secondary occupations. *SYMBOLIC EFFECT*: Rennecker and Cutler make several suggestions which may help to counterbalance the loss of a breast in terms of its symbolic meaning. They recommend that any past feminine achievements should be introduced into the discussion to offset the sense of loss. "The husband's aid has to be enlisted privately, so that he can be impressed with the importance of his role preoperatively and postoperatively. He should be instructed to be particularly tender, loving, and attentive during these phases. He should play up her other feminine charms through hospital gifts of clothes, cosmetics, and other items calculated to refocus her attention on still-present points of feminine pride." *DISTORTIONS IN THE BODY IMAGE*: It is sometimes helpful for a patient to obtain insight into the fact that his reaction is partly determined by early conditioning experiences which caused him to magnify the value of an organ and to minimize the value of other parts of his body.

What is an appropriate response to the loss of an organ? In this section we will consider those instances in which there is no great distortion in the meaning of an organ. Here the reaction to its loss will depend upon: 1) the *FUNCTION* it serves and 2) the *REPRESENTATION* it has *in the body image* based upon an actual rather than a fantasied picture. Thus there would be a more marked response to the amputation of a limb than to the removal of a gall bladder since the former is very important functionally and has a prominent part in the body image while the latter can more easily be dispensed with functionally and has an insignificant representation in the body image except when it causes localized pain.

The appropriate reaction to the loss of an important organ can best be understood if it is likened to the loss of a close relative. In both cases there is a period of mourning (depression) which may vary from a few days to several weeks. In both, too, there will be concern with what is done with the lost object. Resolution will occur gradually and as it proceeds, the patient will become less preoccupied with what was lost and more concerned with what is left.

You should note the severity and duration of the depression because when it is moderately deep and becomes gradually less intense you may consider it a normal mourning process, whereas when it is unduly severe or prolonged, you should regard it as a pathological mourning reaction. In the former instance understanding and sympathy mixed with some diversion is all that is necessary since an internal resolution of feelings will occur in due time. In the latter instance, however, psychiatric consultation is in order since there is unduly great suffering and the danger of suicide.

Question (Name of inquirer not recorded): Dr. Hollender, would you like to comment on the management of a patient who is afraid of cancer and does not have it?

Dr. Hollender: Actually one must divide patients of this type into three separate groups.

Patients of the first group may come to your office because they identify their own symptoms with possible symptoms of cancer suggested in most instances by popular magazines. They usually accept negative findings after a thorough physical examination. They respond best to a strong statement. The physician who feels that he must maintain an avenue of escape by saying, "I believe you do not have cancer" seriously disturbs their peace of mind. It is questionable wisdom to convey reasonable scientific doubt to the patient of this type.

The patients of the second group resemble those of the first group, but hesitate to openly express concern. Indirect statements and oblique references may reflect their apprehension. Only the physician who recognizes the hidden anguish can bring the question out into the open, and then directly reassure the patient.

The third group consists of patients who have a deep seated phobia of cancer. Their anxiety is overwhelming. They might sincerely try to be reassured, but they are not. Persuasion will be of no avail and reports from the laboratory will be doubted. I remember a physician who looked at the biopsy of a benign nodule on his larynx and promptly stated that it had

been substituted for a slide which showed his malignancy. You are dealing here with a deep seated psychiatric problem which requires referral to a psychiatrist.

Lt. Col. William G. Bradley, USAF M. C.: What are your yardsticks, Dr. Hollender, for telling a patient that he does have cancer?

Dr. Hollender: We have no rules of thumb, but we believe that a clear appraisal of the patient's circumstances will give us at least part of the answer. We should be familiar with: (1) the patients total life situation, (2) his current adjustment pattern, (3) his previous handling of life stress, (4) his attitudes and general out-look, and (5) his current home situation. Even then it is difficult to predict how the patient is going to respond, because his response will be conditioned by other factors, for instance the location of his lesion, the prognosis and practical considerations which may include his religious belief and his economic status. Some physicians prefer to be guided by the patient. As a whole, this is a dangerous procedure. Some patients may be afraid to ask questions about the diagnosis. If the truth is to be told, it is probably a good technique to combine it with the clearly worked out program so that the patient has something to hold on to. One must be on one's guard, on the other hand, if the patient says that he can accept the truth no matter how bad; too many are whistling in the dark.

Gradual telling is probably an undesirable compromise since it may make the patient more anxious. If the prognosis is good, hope is the greatest psychological asset. Even so, the right setting is imperative. The facts should be told in privacy so that the patient has adequate time to absorb them and to clarify his thinking. It should be your goal to have the patient accept his situation as an inevitable fact with necessary seriousness, but without excessive gravity.

If the prognosis is poor, the physicians role becomes even more important. So often one finds that physicians are too busy to visit incurable or dying patients. They are trying to avoid the feeling of hopelessness, impotence, and perhaps defeat which must be acknowledged if life cannot be prolonged. One must be aware of the forces within ones self in handling incurable patients. Taylor and Slaughter say that there is a hard way and a soft way to handle patients who have a rapidly growing cancer and metastases. The hard way: tell him that he is going to die and there is nothing you can do to control his illness. The hard way means complete rejection. The soft way is your promise to give him your help and your support when he needs it most.

Lt. Col. Bradley: If you are in doubt whether or not to tell a patient that he has cancer, would you inform his family about it?

Dr. Hollender: Yes, someone ought to be told. But one must be almost as certain of the relative of the patient as of the patient himself. Physical appearance doesn't always permit prediction of emotional stability. The frail, old mother may be a pillar of strength while her husky, virile-looking son may crumble under the impact.

‹‹‹ ›››

External PANCREATIC FISTULAS

Peter C. Rumore, M.D., Effingham

STUDY of the external secretion of the pancreas in man has depended on the collection of pancreatic juice in one of two ways. Firstly, by means of ingenious multiple lumen tubes aspiration of the duodenum has been accomplished. The study of this fluid is complicated by mixture with succus entericus and bile. Secondly, secretions may be obtained from external pancreatic fistulas. In this case, secretions are uncontaminated, but do have an unphysiologic exit and may be affected by the underlying pathologic condition.

A review will be made in this presentation of the characteristics of, and factors affecting external pancreatic secretion, and also the excretion of certain substances in this secretion. The treatment of external pancreatic fistula will be outlined. This data will be correlated with the results of many personally conducted procedures on a case of external pancreatic fistula, which was observed and studied for a period of nine months. This includes the effect of certain factors on the amount of pancreatic secretion, and the excretion of antibiotics through the pancreas.

This study should be of value in increasing the knowledge of pancreatic function, in the choice of treatment of external pancreatic fistula, and in the understanding of pancreatic disorders.

Etiology: External pancreatic fistula results from direct penetrating trauma or from surgery. The surgery most likely to result in a fistula consists of: 1. Marsupialization of a pancreatic cyst, 2. accidental injury to the pancreas during procedures on nearby organs, and 3. resections of portions of the pancreas.

The first category is well illustrated by the following case history:

Case 1: This 43 year old white male, laborer, was admitted with a diagnosis of recurrent pancreatitis, manifested by repeated attacks of epigastric pain radiating to the left lumbar region accompanied by nausea and vomiting. During these attacks, serum amylase rose to 240 units (normal is 40), and serum lipase to 200 units (normal is 120). Relief was obtained only by narcotics. He lost weight rapidly. A gradually enlarging mass was palpated in the epigastrium. Two months after admission, surgery was performed. A pancreatic cyst presenting between the stomach, spleen, and splenic flexure of the colon was marsupialized. Two liters of a green, viscid fluid were evacuated. Analysis of this fluid revealed 181 units of amylase and 436 units of lipase. The postoperative course was uneventful with rapid gain in weight and strength. However, a sinus with an opening 4 mm. in diameter persisted in the center of the scar until its excision by surgery, nine months later. Through this opening there was a continuous discharge of a clear opalescent fluid, which produced a severe very distressing skin excoriation. A polyethelene tube, 4 mm. in diameter was placed in this opening for a distance of 5 cm. Thus the secretions did not contact the skin, allowing it to heal. The secretions were easily collected for analysis. The injection of lipoidol through this tube revealed a channel to the tail of the pancreas. There was no connection between this and any ducts leading to the gastro-intestinal tract. This is a case of a pancreatic cyst, the latter being secondary to a recurrent pancreatitis.

That injury to the pancreas does not always result in permanent pancreatic fistula is well exemplified by the following case.

Case 2: A 34 year old white male, laborer, was operated elsewhere for a complicated duodenal ulcer. According to the operative record, the ulcer and adjacent duodenum were shaved off the pancreas, with evident injury to the pancreas. Ascites and a rapidly downhill course ensued two weeks after surgery. Several abdominal paracenteses were necessary, up to 5,500 ccs. of a clear, opalescent fluid being removed at one time. Fluid analysis revealed an amylase of 174 units and lipase of 460 units Serum amylase was 111 units, and serum lipase was 122 units. A diagnosis of chemical peritonitis due to leaking pancreatic juice was made. There was no evidence of a purulent peritonitis. Under local anesthesia several rubber drains were placed through an abdominal incision into the region of the head of the pancreas. A large amount of clear, opalescent fluid was evacuated. Two weeks later, drains were

placed in the right lower quadrant because of a localized collection of fluid there. He made an astounding and uneventful recovery, gaining 50 pounds in two and a half months. After removal of the drains, the amount of fluid drainage from the wounds rapidly decreased, with healing of the wounds in two weeks. Apparently, not only must a pancreatic duct be injured, but its connection with the gastrointestinal tract must be completely blocked for a permanent external pancreatic fistula to develop. This, then, must be considered a temporary external pancreatic fistula.

Pancreatic Secretion: The secretion of the pancreatic juice is conceded to be under the control of both humoral and neural factors. In general, the humoral factors are elaborated by the stomach, and duodenum in the form of secretin and pancreozymin.[1] The neural factors are associated with the autonomic nervous system. Vagal stimulation will increase the amount of secretion slightly, but will make the secretion markedly viscid. In general, cholinergic drugs increase secretion, whereas adrenergic drugs decrease secretion. It must be remembered that these drugs also act on the formation of secretin and pancreozymin, so that neural factor cannot be completely dissociated from the humoral factors.

The characteristics of pancreatic secretions collected through external pancreatic fistulas have been well recorded by many investigators. These are summarized in Table 1. The largest

TABLE 1

CHARACTERISTICS OF PANCREATIC FISTULA FLUID:

	Reports	*Case 1*
Amount:	30 to 1770 cc/day	12-150 cc/day
Color:	Clear, opalescent	Same
Sp. Grav.:	1.002 to 1.015	1.012
Ph:	7.5 to 8.4	7.5 to 9.0

volume reported was 1770 ccs. per day in a 25 year old male following a gunshot wound.[2] This man had normal gastro-intestinal function with good fat digestion so that it was assumed that at least 700 ccs. of pancreatic juice entered the duodenum. Thus, the total amount of juice secreted by the pancreas in this patient must have exceeded 2400 ccs. per day, far in excess of any previous estimate.

The chemical constituents of pancreatic juice are summarized in Table 2. It is evident that

TABLE 2

CHEMICAL CONSTITUENTS OF PANCREATIC FISTULA FLUID:

	Reports		*Case 1*	
Sodium	134-149	mEq/L		
Potassium	3.8-5.4	"		
Magnesium	0.28-0.78	"		
Calcium	0.4-4.7	"		
Chloride	35-105	"		
Bicarbonate	30-78	"		
Total Proteins	190-800	mgm.%	260-500	mgm.%
Albumin	60-500	"	140-300	"
Globulin	40-300	"	120-200	"
Urea Nitrogen	5-20	"		
NPN	14-39	"		
Uric Acid	0.12-1.22	"		
Sodium Chloride			355-521	mEq/L

large losses of pancreatic fluid through an external pancreatic fistula can lead to fluid and electrolyte imbalance. This is often manifested as a sodium and bicarbonate deficiency.[3] Rarely a calcium deficiency may be noticed.

The main enzyme constituents of pancreatic juice consist of trypsin, lipase and amylase. (Table 3). The concentration of these vary wide-

TABLE 3

ENZYME CONSTITUENTS OF PANCREATIC FISTULA FLUID:

	Reports	*Case 1*	*Case 2*
Amylase:	1325 units	1350 units*	174 units
Lipase:	5290 units	435 units*	460 units
Trypsin:	1089 units	not tested	not tested

*Average of 26 specimens

ly, depending on many physiologic and psychic factors. In general, vagal stimulation produces a secretion with more concentrated enzymes, whereas secretin stimulation results in a larger amount of a more dilute secretion. Amylase and lipase are readily tested by direct digestive tests. However, trypsin is present in the inactive form, trypsinogen, and must be activated prior to testing. Trypsin testing is difficult, has not been too well standardized, and therefore is rarely reported. Three authors [4,12,13] have reported trypsin activity, each using a different substrate. No correlation can be found in their figures.

Factors Affecting Pancreatic Secretion: Factors which have been tested by various investigators on the secretion of juice through an external pancreatic fistula are listed in Tables

TABLE 4
FACTORS INCREASING PANCREATIC FISTULA SECRETION:

Oral:	
Food*	Water (a)
Hydrochloric Acid	Whiskey (a)
Coffee (a)	
Duodenal Instillation:	
Food	
Parenteral:	
Secretin*	Pilocarpine (a)
Mecholyl chloride (a)	Caffeine
Histamine	I.V. fluids in large amounts
Physostigmine (a)	
Psychic:	
Food anticipation (a)	
Miscellaneous:	
Splanchnic block	

*Noted in Case 1.
(a) Contrary action also reported.

TABLE 5
FACTORS DECREASING PANCREATIC FISTULA SECRETIONS:

Oral:	
Hunger*	Magnesium Sulfate
Gastric suction*	Bile salt
Banthine*	Olive Oil (a)
Duodenal Instillation with Gastric Suction:	
Olive Oil	Sodium bicarbonate
Water	
Parenteral:	
Atropine*	Morphine*
Banthine* (a)	Demerol*
Epinephrine	Tetra ethyl ammonium chloride
Ephedrine	Dihydroergotamine
Papaverine	Amyl nitrate
Psychic:	
Psychic trauma	
Miscellaneous:	
Smoking (a)	

*Noted in Case 1
(a) Contrary action also reported.

TABLE 6
FACTORS HAVING NO EFFECT ON PANCREATIC FISTULA SECRETION:

Oral:	
Sodium bicarbonate (a)*	
Dextrose-50%	
Ephedrine*	
Cortisone	
Instillation into jejunum:	
Food	
Parenteral:	
Strychnine	Isotonic saline IV
Furmethide	5% dextrose in D/W IV
Sodium luminal	Ethyl alcohol IV

*Noted in case 1
(a) Other action also reported.

4, 5, and 6.[2,5–11,14] Many of the established tests were not repeated in this study because of the emphasis placed on the excretion studies. The factors tested in Case 1 are indicated in the tables. Some of the factors tested and reported have given contrary results. These factors are listed under the dominant action, with a note made that contrary action was reported by at least one investigator. In general, the most potent factors in decreasing pancreatic secretion are gastric suction, Banthine, atopine and ephedrine. The latter did not decrease secretion in our tests. Secretin injection is the most potent stimulant of pancreatic secretion. It will nullify the effect of gastric suction, and its effect will only be diminished by Banthine or atropine.

Pancreatic Excretion: Only in recent years has the excretion of various substances through the pancreatic juice been studied. (Blood levels and pancreatic excretions of antibacterial agents are listed in Table 7). Excretion of antibiotics has been studied by one group of investigators (Howard, et al)[11]. In a personal communication, Howard reports that finding of penicillin in pancreatic secretion has been confirmed in several cases. In our case, the absence of penicillin activity in the secretion can be explained by the development of a penicillinase. The Choloromycetin test in our case cannot be considered valid, due to resistance of the test organism to this antibiotic.

In a masterful paper on antibiotics for surgical infections of the gastro-intestinal tract, Pulaski[15] notes that sulfanilamides, penicillin and streptomycin administered parentally were recovered in secretion from pancreatic fistulas in three such cases. Aureomycin, chloramphenicol, terramycin and polymyxin could not be thusly recovered.

The treatment of pancreatic fistula:

Most pancreatic fistulas close spontaneously within six to eight weeks after their occurrence. The problem is the choice of treatment in persistent pancreatic fistula.

The first consideration is the general support of the patient. Fluid and electrolyte, especially sodium, bicarbonate, and often calcium, replacement is necessary if large amounts of pancreatic juice are lost. Nutritional deficiency due to poor digestion must be corrected by collecting

TABLE 7

ANTIBACTERIAL AGENT EXCRETION THROUGH PANCREATIC FISTULA:

Agent	*Reports*		*Case 1*	
	Serum	Secretion	Serum	Secretion
Penicillin	——	"High concentration"	7.5 units/cc	0
Streptomycin	——	"Sl. activity"	11*	2*
Aureomycin	——	"No activity"	2.4*	0
Chloromycetin		Not reported	0	0
Terramycin		Not reported	1.5*	0
Sulfanilimide[12]	8.5 mgm.%	8.5 mgm.%	not tested	
Sulfadiazine[13]	8.1 mgm.%	8.1 mgm.%	not tested	

*Expressed as micrograms per cc.

the pancreatic juice and returning it to the digestive tract by means of a stomach tube or by flavoring it with grape juice. Any associated abnormal condition such as anemia must be corrected.

An important consideration is the protection of the skin around the fistula. Pancreatic juice is very irritating to the epidermis, especially if some serum is present to activate trypsinogen. The most successful method of protection of the skin is to cannulate or intubate the fistula so that the secretions may be collected in a container and thus do not come into contact with the skin. Aluminum paste, Ladd and Gross paste, or silicone cream may be of benefit to irritated skin after the flow of juice has been diverted.

Once the satisfactory general status of the patient has been assured, conservative measures may be utilized. The oldest reported regime was instituted by Wohlgemuth in 1907. It consists of a high fat, low protein, carbohydrate free diet with large doses of sodium bicarbonate by mouth. Thus, empirically, these deficiencies were corrected before they were postulated by modern clinical and laboratory means. Also, suggested have been exclusive parenteral feedings, and other agents and foodstuffs which have been shown to decrease pancreatic secretions in any and all combinations. At present, Banthine seems to be the drug of choice. A word of caution in using powerful antisecretion agents is in order. In case 1, with Banthine and gastric suction the amount of secretion was markedly decreased, but the viscosity was increased to the point that the tube became plugged. This led to an exacerbation of pain with increased serum amylase and lipase, requiring narcotics and fluids for relief. Several investigators feel that the very process of restoring and maintaining fluid and electrolyte balance will often lead to spontaneous closure of the fistula. This is true if communication exists between the fistulous tract and the gastri-intestinal tract by means of pancreatic ducts, as was probably the situation in Case 2.

If there is no improvement in six weeks to six months, or if it is too difficult to maintain the status of the patient, surgical correction must be instituted. Surgery consists of : 1. Dissection of the fistula with implantation of the distal end into the gastrointestinal tract; 2. Dissection of the fistula to its junction with the pancreas, and excision of the fistula at this point; 3. Dissection of the fistula to the pancreas, and excision of the portion of the pancreas and fistula en bloc. This latter procedure can only be used if the distal portion of the pancreas is involved.

The first method is often the only possible one. The second is used only as a hopeful last resort since it is often unsuccessful. The last method is the most desirable.

In Case 1, ten months of observation and conservative therapy, including Wohlgemuth regime, gastric suction, Banthine, atropine and ephedrine resulted in no improvement. At surgery, it was possible to resect the fistulous tract and the distal four centimeters of the tail of the pancreas en bloc. Recovery was uneventful.

SUMMARY

1. A resume of the etiology, secretion, excretion, and treatment of external pancreatic fistula has been presented.

2. The findings in a case of permanent, and one of temporary external pancreatic fistulas are correlated with reports in the literature on external pancreatic fistulas.

3. Of the factors affecting pancreatic secretions, secretin is the most potent stimulant, and gastric suction and Banthine are the most potent depressants.

4. Of the antibacterial agents, penicillin, streptomycin, sulfanilimide, and to a lesser extent, sulfadiazine is excreted in the pancreatic juice.

5. A plan of approach to the treatment of external pancreatic fistula has been presented.

6. Caution is urged in the use of potent antisecretion agents because of the possibility of inspissation of secretion and blocking of the outlet channels. This may also be of importance of other types of pancreatic disorders.

REFERENCES

1. Harper, A. A. & Raper, H. S.: Pancreozymin, a stimulant of the secretion of pancreatic enzymes in extracts of the small intestine. J. Physiol. **102**:115-125 (June 30), 1943.

2. Miller, J. M. & Wiper, I. B.: Physiological observation on patients with external pancreatic fistula. Ann. Surg. **120**: 892 Dec. 1944.

3. Miller, J. M., Ginsberg M. and Lipon, R. J. The treatment of external pancreatic fistula. Postgrad Med. **10**:31 July 1951.

4. Wohlgemuth, J. Untersuchungen ueber das Pankreas des Menschen. Berl. Klin. Wchnsche. **44**:47 1907.

5. McCaughan, J. M. and Purcell, H. K. Pancreatic fistula: Clinical and experimental observations. Arch. Surg. **43**:269 Aug. 1941.

6. Thomas, P. O. and Ross, C. A. Effect of exclusive parenteral feeding on the closure of a pancreatic fistula. Arch. Surg. **57**:104 July 1948.

7. Miller, J. M. & Ginsberg, M. Physiological observations on a patient with an external pancreatic fistula. Arch. Surg. **61**:346 Aug. 1950.

8. Newman, E. A. & Eisenstein, M. Observations on a patient with pancreatic fistula. Gastroent. **13**:528 Dec. 1949.

9. McCaughan, J. J., Sinner, B. L. and Sullivan, C. J. External function of the human pancreas: Physiological Observations. Arch. Int. Med. **61**:739 May 1938.

10. Comfort, M. W. and Priestley, J. T. External pancreatic fistula: Report of a case with physiological observations and surgical considerations. Proc. St. Meet. Mayo Cl. **18**: 22 409. Nov. 3, 1943.

11. Howard, J. M., James, C. L. and Evans, S. S. Physiological studies on the external pancreatic secretion in man. Surg. Forum, A.C.S. 577 1951.

12. Kahn, J. and Klein, H. M. Human pancreatic secretion studies from a case of external pancreatic fistula. Am. J. Med. Sc. **184**:503 1932.

13. Edwards, H. C. Pancreatic fistula implanted in the stomach. Lancet **1**:137 Jan. 1942.

14. Mahaffey, J. H. and Haynes, B. W. Observations on pancreatic juice in a case of external pancreatic fistula in man. Amer. Surg. **19**:2 p 174 Feb. 1953.

15. Pulaski, E. J. Antibiotics for surgical infections of the gastro-intestinal tract. S.G.O. **97**:3 p. 353. Sept. 1953.

‹‹‹ ›››

Exfoliative cytology

The future will see the cytologist invited into the operating room itself for the help he can give the surgeon. One author has reported a technic of making smears rapidly from lymph nodes and using the findings as a guide in deciding the extent of node excision in conjunction with surgery for cancer of the cervix. Others have examined neurosurgical material with help in doubtful cases. In many areas of the body surgery can now be extended with reasonable safety to limits never previously envisioned and, as a consequence, the question is raised more and more frequently whether treatment may not sometimes be more radical than the disease warrants. Obviously, the one fact that can decide this question in the presence or absence of microscopic extension of cancer at the periphery of dissection. Frozen-tissue examination is a help but only if the pathologist knows where to take the section for study, and in the absence of gross tumor, this is guesswork. One can visualize the possibility of making multiple smears from the areas most likely to be involved and then using the tissue technics in the specific localities that show a suspicious cytologic picture. *Howard Ulfelder, M.D., Exfoliative Cytology. New England J. Med., May* 27, 1954.

Management of VARICES IN PREGNANCY

Rocco V. Lobraico, Jr., M.D., F.A.C.S., Chicago

ONE of the most distressing problems in pregnancy is the varicose vein. The esthetic sense and physical comfort of the patient is greatly disturbed. It is a difficult manifestation for the physician to control and at times causes him to convey an attitude of indifference. The patient meanwhile anxiously awaits the termination of pregnancy before relief is obtained.

The physiological changes in pregnancy, with an enlarging uterus produce an increase in the intra-abdominal tension with a proportionate increase in the hydrostatic pressure in the lower limbs. A competent and strong saphenous system may become relatively incompetent and dilate during pregnancy because of its normal elasticity. Hydrostatic pressure is transmitted through the communicating veins between the superficial and deep systems. The pressure increases towards the ankle because of gravity. In the gravid there is an additional factor of a 30% increase in the total blood volume with a 40% increase in the plasma volume. The hydremia reaches its maximum at the seventh month of pregnancy at which time it remains constant or gradually diminishes.

During pregnancy all subjective and objective manifestations of varicose veins are accentuated. In the vulvar and lower extremities there is pain and edema on prolonged standing. Improvement occurs on walking but again becomes annoying after protracted standing. When the patient arises from a recumbent or sitting posture a sudden jarring sensation is experienced in the legs as the varicose veins rapidly distend. There is soreness in the calf muscles and skin over the course of varicose veins. A heavy throbbing pain is noted in vaginal varices.

Presented before the Section on Obstetrics and Gynecology, 114th Annual Meeting, Illinois State Medical Society, Chicago, May 18, 1954.

Objectively the veins are either visible or palpably dilated. They are usually tortuous throughout the distribution of the vulvar or saphenous system. Localized bulging in the wall of the saphenous or its tributaries represents a blow out formation at the level of an incompetent perforating tributary.

Complications may appear as a sudden massive hemorrhage from a dilated friable superficial varix occasionally following even minor trauma. It may occur in the vagina, vulva, or legs. During childbirth a vaginal or vulvar varix may rupture spontaneously with descent of the head obstructing delivery by a huge dissecting hematoma. It may occur in the primipara as well as a multipara. A hematoma may follow an episiotomy or laceration through a varix by forceps extraction. The hematoma may dissect its way upward between the connective tissue retroperitoneally to the level of the kidney or even the diaphragm resulting in a fatality. Ruptured varices in the junction between the upper and lower uterine segments may cause a fatal internal hemorrhage. Intraligamentous hematomas have also formed during a delivery. Subcutaneous ecchymosis with trivial trauma is a relatively frequent complication.

Edema of dependent parts associated with varicosities appear in the vulva and the lower extremities. Hemorrhoidal veins can develop varices either coexistent with or in the absence of varicosities elsewhere. Thrombi in hemorrhoidal veins as well as rupture and bleeding with fissure formation may occur. Thrombosis in vulvar varicosities are extremely painful.

Thrombophlebitis is more common in the varicose veins of pregnancy. It may occur in the antenatal period. It is due to a combination of low grade infection and malnutrition in the vessel wall. Immobilization for long periods

of time in bed with an associated illness causes a retardation in the return flow that is already impeded by direct pressure precipitating an infected thrombus of the veins. Injury affecting the superficial veins of the legs must be a distinct possibility as a result of the contortions in the stirrups during delivery. While the majority of thromboses are of the non-inflammatory nature there is no doubt that infection plays an active role in some instances. Septic thrombophlebitis and fatal septicemia are not an unkown sequelae from cellulitis or erysipelas in the leg with nutritional impairment. Varicose ulcers may appear before there is a marked increase in the intrapelvic pressure. Cellulitis produced by the hemolytic streptococcus starts at the edge of these ulcers; it is marked by a sudden intensification of pain and systemic toxemia.

The incidence of thrombophlebitis and pulmonary embolism is no greater following delivery than that following general surgery. Pulmonary embolism may occur before or after thrombophlebitis manifests itself clinically. Matthews[1] reports fatal cases commonly occur within the first 10 days postpartum. The remaining fatal cases between 11 and 35 days postpartum.

The treatment of varicose veins in pregnancy depends upon the period of gestation that the manifestation is symptomatic. In the early trimester the varicose veins are not prominent, but become progressively noticeable. Conservative management with sclerosing agents, elastic stockings and tensor bandages have been successful in the isolated localized segment of varicosity of the leg with no associated incompetent vein as yet developed. The effect of the rubberized stocking is one of compression controlling the associated interstitial edema. To be effective the elastic stocking must be measured to conform to the leg extending above the knee to a level in the thigh which adequately compresses the weakened saphenous system. Elevating the extremity a few hours each day will aid in diminishing the muscle fatigue and the dependent edema. The isolated localized segments of varicosities with no associated incompetent vein are generally secondary in character and will regress after pregnancy in most cases.

Varicose veins associated with one or more incompetent veins in pregnancy as well as at other times is best treated surgically. Sclerosing substances are not recommended since they will not work in a high pressure dilated system, and if they do locally obstruct the vessel, the high pressure will merely bring about the development of collateral varicose veins. Julian[2] advises the intra-luminal stripping before the fifth month of pregnancy. Extra-luminal stripping with individual ligation of the perforating branches may be required if there has been a segment of pre-existing obstruction in the saphenous system.

If the patient is examined after the fifth month and found to have varicose veins that meet the surgical criteria, then ligation of the saphenous vein and its tributaries at the fossa ovalis is performed. An elastic stocking is then worn day and night and must extend above the knee to be of any value. Sclerosing substances may be injected after 3 to 6 months postpartum into the remaining varices.

Intraluminal stripping is not recommended after the fifth month of pregnancy for fear of causing a deep vein thrombosis. The circulation in the deep veins are under increased hydrostatic pressure which may lead to clot formation in the sites of the avulsed perforating vein. Pulmonary embolism may be a consequence or there may be embarrassment of the return circulation in the lower extremity.

The painful vulvar varicosity is treated with tight compression employing the vulvar pad. If the vulvar veins becomes thrombosed they are ligated and resected.

Vaginal varicosities cannot be treated prenatally. When hematomas form before, during or after delivery they are evacuated. No attempt at ligation is made since wherever the needle is inserted varicosities are encountered producing more bleeding. The best control is a tight vaginal pack for 24 to 36 hours.

Hemorrhoids are reduced easily by the patient for comfort. Anesthetic ointments, suppositories and lubrication are adjuncts in the control. The thrombotic hemorrhoid requires excision of the clot. Definitive surgery for hemorrhoids should be postponed until 6 weeks postpartum when the edema has subsided.

Varicose ulcers may follow sclerotherapy during pregnancy if given after the fifth month. Ulcerations may appear before there is a marked increase in intrapelvic pressure. Varicose ulcers

can be prevented by treating varicose veins early with special care. Treat deep vein thrombosis properly. Prescribe foot care and fungus eradication to prevent eczema. Control the weight and protect the limbs against trauma. Avoid prolonged standing.

Ecchymosis can be treated by applying external pressure and elevating the leg. After active bleeding has ceased hasten absorption of blood with either dry or moist heat. Cellulitis and erysipelas are controlled by heat, rest, elevation and anti-biotics. Eczema has been treated with x-ray therapy and paravertebral block.

Thrombophlebitis may be prevented by caution during the delivery of a patient with varicose veins. Do not keep the patient in stirrups too long and cushion the popliteal space against rigid sharp supports. If possible, delivery without stirrups would be better. Daily palpation of varicose veins for thrombi or tenderness along the saphenous system will forewarn the physician. Not only must we consider potential infection in the saphenous but also the pampiniform plexus if the patient develops a course of low grade fever with pelvic discomfort. With extensive vaginal manipulation and instrumentation, prophylatic chemotherapy is recommended.

Early ambulation has reduced but not prevented the frequency of thrombophlebitis. The management of acute thrombophlebitis is a debatable issue. Bed rest with elevation of the leg, dry or moist heat application plus chemotherapy affords good results. Others advocate ligation of the saphenous vein and its tributaries at the fossa ovalis with antibiotics and early ambulation. Dicumoral and heparin have been discouraged in pregnancy because of uncontrolable hemorrhage from the uterine sinuses. Conrad Collins[3] will ligate the vena cava and ovarian veins as a life saving measure in ascending severe thrombophlebitis. He reports 59 cases of acute suppurative thrombophlebitis with ligation of the vena cava and ovarian veins in patients failing to respond to a medical regimen after 4 to 5 days. 88 per cent survived and 12 per cent died. Lumbar sympathetic blocks or resections are done relieving arterial spasm occasioned by ligation of a large venous trunk.

The prognosis for varicose veins in future pregnancies even though treated is not encouraging. They will become progressively worse if not treated and those that are treated develop incompetent veins from the remaining saphenous elements. Thrombophlebitis which appeared to be cured during the last pregnancy and was quiescent during the intervening non-pregnant state will suddenly flare up in subsequent pregnancies. Failure to recover results in permanent varicosities which may be due to inherent connective tissue deficiency, hormonal changes, anatomical variations, heredity, obesity, defective valves and occupation.

SUMMARY AND CONCLUSIONS

The management of varices in pregnancy is generally a palliative measure. Regardless of whether the management is conservative or surgical, the varicosities will recur in new components in subsequent pregnancies. Caution should be exercised during delivery to prevent complications. Close observation for thrombophlebitis will initiate early therapy and reduce the morbidity.

30 N. Michigan Ave.

REFERENCES

1. Matthew, G. D.: Thrombophlebitis in Pregnancy, Edinburgh Medical Journal **54**:641-648, 1947.
2. Julian, O. C. Personal Communication June 28, 1954.
3. Collins, G. G., Nelson, E. W., Ray, C. T., Weinstein, B. B., and Collins, J. H., Ligation of the Vena Cava and Ovarian Vessels, Am. J. Obs. & Gyne. **58**:1155-1166, 1949.

CESAREAN SECTIONS in a Nonteaching General Hospital

William W. Curtis, M.D., Springfield

THE increasing use of cesarean section in recent years has followed in normal sequence the improving surgical technique, availability of blood, antibiotics, and much improved anesthesia. These factors have removed cesarean section from its first use—the emptying of the pregnant uterus of dead or dying women during the reign of the Roman Kings—to a life-saving operation in our modern operating rooms. In view of these facts, we are frequently warned of a trend toward over-utilization of this procedure.

MATERIAL

This is a report of 289* consecutive cesarean sections in a 250 bed general hospital in central Illinois, the Springfield Memorial Hospital. All operations were performed by members of the Staff, including obstetricians, general surgeons and general practitioners. The youngest patient was 17 years, the oldest 45, with an average age of 28.1 years.

INCIDENCE

Table No. 1 shows the increasing incidence during the period covered.

	Total Deliveries	Sections	Per cent
1948	1029	39	3.79
1949	1031	45	4.36
1950	951	44	4.62
1951	1042	59	5.66
1952	1129	44	3.89
1953	1149	58	5.57
	6331	289	4.4 average per cent

*13 records unsuitable for analysis; total used 276.

This increasing instance follows the progress in improved safety of the procedure and the broadening of the indications. We no longer hear the old dictum, "The lower the ceserean section rate the better the obstetrical service". I feel that this increased use is warranted, but we must take care to use it only when indicated. Our incidence varied 3.79% to 5.66%, with an average of 4.61%. This compares favorably with incidence throughout the country. D. G. Tollifson reports 11%. M. Edward Davis[2] reports approximately 5%. William E. Studdiford and Wayne H. Decker[3] report slightly over 4%. In our hospital there have been no high forceps deliveries during these years, and this is certainly the result of the increasing use of cesarean section.

AGE AND PARITY

Table 2

Parity	Age 17-25	Age 26-35	Age 36-45	Total
0	45	22	5	72
I	37	50	15	102
II	22	30	11	63
III	2	15	5	22
IV & over	3	5	9	17
	109	122	45	276

The great majority of the cesarean sections occur in the small parity patients due to the high incidence of cephalopelvic disproportion and previous section in this group. In this series, 184 sections (66.6%) were done for one of these indications. Another factor is the practice of the great majority of our Staff to do a sterilization procedure at the time of the third cesarean section.

INDICATIONS

Table 3

	Cases	Per cent
Previous section	124	44.9
Cephalopelvic disproportion	60	21
Toxemia	22	7

Presented before the Section on Obstetrics and Gynecology, 114th annual meeting, Illinois State Medical Society, May 18, 1954, Chicago.

Placenta praevia	20	7
Premature separation of placenta	10	3
Malposition (Transverse 5; Extended head 1; Large breech 1; Compound 2)	9	3
Diabetic	5	2
Others	26	9

The 9% shown as *others* in Table 3 includes previous gynecological surgery, cardiac disease, kidney disease, pelvic tumor, increasing anti-Rh titre, congenital anomalies in the mother, inertia, ruptured uterus and others. Some of these indications are not generally accepted by many authorities. The literature is peppered with articles suggesting vaginal delivery after previous sections. I think this is a worthy procedure in selected cases and under ideal hospital conditions. The majority of downstate physicians do not have such facilities; therefore, I practice, "Once a section always a section". A few ruptured uteri made a strong impression on your essayist. My experience with pregnancy in cardiacs is limited, but I have found no occasion to go contrary to my teaching that cesarean section is of no benefit in cardiac patients unless there is a definite obstetrical indication. The use of cesarean section in cases of rising Rh-antibody levels remains of questionable value; certainly it should not be used before the 37th week, because the problem of prematurity is encountered. Premature separation of placenta and abruptio placentae are treated by both vaginal and operative delivery. The former is preferable but I do not hesitate to operate if labor does not ensue after rupture of the membranes.

OPERATIVE PROCEDURES

The cases were almost equally divided between low cervical and classical sections, 130 and 141 respectively. There were five Porro sections which were done for hemorrhage or uterine pathology. The operators were 142 cases by specialists and 134 cases by the general surgeons and general practitioners. There were 100 bilateral tubal ligations, two ovarian cystectomies, seven appendectomies, and three myomectomies, at the time of cesarean section. I personally feel that the doing of an elective appendectomy at the time of a cesarean section is meddlesome surgery.

The routine use of tubal ligation, only with the patient's wholehearted agreement, after the third cesarean section is open to question but is generally accepted. I have done a fourth section and assisted on a sixth, but I felt both procedures were rather foolish maternal risks because all previous children were living and well. Regardless of the low morbidity and mortality in cesarean section, I feel that each section is a major operation with a definite risk (over and above that of normal vaginal delivery) to the mother and that three such risks to provide a family are enough for one patient.

POSTOPERATIVE COMPLICATIONS

Table 4

Hemorrhage	3
Phlebitis	3
Ileus	2
Pyelitis	2
Pleural effusion	1
Cardiac decompensation	1
Hematoma abdominal wound	1
	13

Table No. 4 shows the postoperative complications totaling thirteen cases. The remaining thirteen morbid cases had no diagnosis to account for morbidity. Anemia is not listed as a complication because it is such a common finding in the portpartum period. All these patients responded to treatment and were discharged within fourteen days.

MORBIDITY AND MORTALITY

There were no maternal deaths in this small series. I realize that the number is too small to be significant—but think what one or two deaths would do to the statistics in such a series.

In this group of patients we have 26 that were morbid, for a total of 81 days of morbidity. (*Morbidity is used to indicate a temperature of* 100.4 *on two consecutive days, excluding the day of surgery.*) This gives a morbidity rate of 9.4%. George S. Zaron reports 13.48% in patients receiving prophylactic penicillin and 36.94% in those not receiving prophylactic penicillin. I feel that this low morbidity is due to the generous use of antibiotics, whole blood transfusions and early ambulation. One hundred and seventy-five patients, 63.4%, received antibiotics and 139 patients, 50.36%, received whole blood transfusions. In view of these facts, I suggest the prophylactic use of antibiotics, but warn that allergy must be carefully checked before. I have a great aversion to giving blood transfusions to an anesthetized patient, except in an emergency,

since I saw two patients die from transfusion reaction without regaining consciousness. I feel it is much safer to give blood after surgery with the patient awake, if possible.

I feel that this and most morbidity reports do not consider a few very important complications: phlebitis, which may occur two to six weeks postpartum and occasionally sends a patient back to bed and the hospital, and occasional bowel obstruction due to a loop of bowel being kinked by postcesarean section adhesions. The latter is one of the complications which may follow any abdominal operative procedure.

SUMMARY

The maternal factors in 276 consecutive cesarean sections have been reported.

There was no mortality and the morbidity was 9.4%.

Prophylactic use of the antibiotics and a generous use of whole blood is urged.

A plea to keep cesarean section for use only when definitely indicated.

BIBLIOGRAPHY

1. South, M. J. **46**: 290, March 1953.
2. S. Clin. North America. **33**: 101, February 1953.
3. Bull. New York Acad. Med. **28**: 640, October 1952.
4. Am. J. Obst. and Gynec. **63**: 122, January 1952.

‹‹‹ ›››

Aspirin versus Cortisone

A detailed report of a carefully controlled experiment on a comparison of cortisone and aspirin in the treatment of early cases of rheumatoid arthritis, carried out by a joint committee of the Medical Research Council and the Nuffield Foundation, deals with 30 patients given cortisone and 31 treated with aspirin. The dose was adjusted individually, and the patients were observed for a year. The course in these two groups was closely parallel in nearly all the reported characteristics — namely, joint tenderness, range of movement in the wrist, strength of the grip, tests of dexterity of hand and foot, and clinical judgment of activity of the disease and of the patient's functional capacity. The only advantage observed was the somewhat more favorable hemoglobin levels and sedimentation rates in the cortisone-treated group; no other differences were noted. On each treatment, the disease became inactive or only slightly active in about three-quarters of the cases. About two-fifths of the patients became capable of normal work or activity, and the therapies in these 61 patients offered surprisingly little choice. An editorial note ends: "It would be ironical if the major practical outcome of the intensive work of the last few years is the discovery that aspirin, given in maximum tolerated doses, is the best and safest treatment for rheumatoid arthritis, the only common disorder for which cortisone is used."

Obviously, the tide is receding although perhaps somewhat more rapidly in Great Britain than in this country. It may now be possible to evaluate more calmly the role, however minor, of adrenocortical hormones in the management of rheumatoid arthritis and other conditions in which they have been used for purposes besides mere replacement therapy. *Editorial, Receding Tide. New England J. Med. Aug.* 26, 1954.

CASE REPORTS



Lightning Pains of TABES DORSALIS Controlled with ACTH and Cortisone

Irving H. Distelheim, M.D. and David M. Cohen, M.D., Chicago

ANYONE faced with the treatment of the patient with tabes dorsalis having lancinating pains is aware of the discouraging results obtained with the use of any of the drugs and/or modalities employed to date. Thiamine chloride, protamide, x-rays of nerve roots, codeine, insulin, chloral hydrate, morphine, etc. have all proven disappointing.

Unfortunately the number of tabetics who suffer from lightning pains is high, ranging from 73% to 88%.[1] These pains continue even after the syphilitic process has been eradicated. This apparently is due to the destructive changes which have occurred in the peripheral sensory neurons by the spirochetal action. However there is some difference of opinion as to the causus operandi of the pains. In 1924 Wagner-Jauregg concluded that the pains were caused by nonspecific agents acting as irritants on nervous tissue that had previously been altered by the specific process of syphilis.[2] The reasoning being that many patients showed no signs and symptoms of progressive tabetic involvement despite the persistence of lightning pains. Orr and Rows[3] also felt that the sensory neurons became accessible to the injurious effects of toxic substances because of the destruction by the tabetic process of the myelin sheaths of the posterior roots at the zone of entrance into the spinal cord.[3]

In view of the reasoning cited above and of the known ability of ACTH and cortisone to counteract inflammatory processes, these drugs came to be considered as a means of controlling the lightning pains of tabes dorsalis.

Mrs. M.D., a 57 year old white female, presented herself at the Mt. Sinai Hospital Clinic with a history of having had a questionable positive serologic test for syphilis sixteen years before. Her present complaints were that of having "shooting pains in both legs for the past ten years—worse in the past four years". About seven years prior to being seen, the patient also noticed that her left ankle had become swollen and that motion was considerably limited. There was no antecedent injury to the ankle. The past history as well as the family history was essentially negative. There was no history of any genital lesions or skin rashes at any time. No treatment was instituted until 1947, when upon rediscovery of the positive serology the patient was given a series of arsenical and bismuth injections along with several courses of fever. The only available laboratory work done at that time in addition to the serological

From the Department of Dermatology, Chicago Medical School.

test, was the spinal fluid examination, which showed a four plus Wassermann reaction and a colloidal gold curve of 5555544432.

Physical examination was negative except for the following findings:

Cranial nerves: Pupils fixed to light and accommodations. Fundi — slight pallor in both discs.

Reflexes: Biceps, triceps, and radial hyper-active on right, normal on left. Patellar and ankle reflexes absent bilaterally.

Mental evaluation: Patient well oriented; no memory impairment—five digits recalled.

Co-ordination: Patient had a marked ataxic gait. Romberg-four plus. Charcot joint of the left ankle.

Laboratory findings: Serological tests for syphilis on March 28, 1949; January 9, 1952; and April 22, 1952 revealed a negative Kahn and Kline test.

Spinal fluid examinations were as follows: December 12, 1950; Wassermann-four plus; gold curve-0000000000; no cells or protein reported. September 17, 1951: Wassermann-positive 32 units; gold curve-1123221000; protein-87.5%; cells not reported. May 19, 1952: Wassermann-positive 8 units; gold curve-2342100000; protein-66%; cells not reported.

Urinalysis and CBC including a differential Schilling count were within normal limits.

X-ray of the left ankle revealed evidence of a complete ankylosis of the ankle joint and tarsus. No evidence of suppurative arthritis. Marked osteoporosis was present. Roentgenological changes were compatible with those seen in Charcot's joint.

In October, 1951 the patient was given 9.0 million units of penicillin with no resultant change in the symptomatic complaints, although the spinal fluid Wassermann titre and protein dropped as seen in the laboratory reports above. The patient was given thiamine chloride, codeine, phenobarbital, and aspirin for pain with no relief afforded by any of these medications.

Method and Procedure: In order to establish a base line for the frequency of occurrence of the lancinating pains, a record was kept for one month. The pains occurred every day or every other day with the exception of one two day pain free period. On March 21, 1953 the patient was admitted to the Mt. Sinai Hospital and ten units of ACTH in 5% glucose was administered intravenously. There was no pain that day, and the dosage was repeated for seven days, with no pain experienced at any time. The patient also noticed an increase in mobility of the left ankle. ACTH was then stopped and cortisone, 100 mgms. daily (25 mgms. every six hours) was given with equal success. This dosage was reduced to 75 mgms. daily (25 mgms. every eight hours) on the third day and to 50 mgms. daily (25 mgms. every twelve hours) on the fifth day, and maintained at this level for the next fourteen days. Thus on steroid hormones the patient was pain free for a period of 27 days. Subsequent removal of the cortisone brought a return of the pain in three days, and a daily dosage of 25 mgms. was found to be an adequate maintenance dose. Spinal fluid examination on May 19, 1953 revealed the following: Wassermann-positive 8 units; protein-54%; cells-0; gold curve-0000000000.

SUMMARY AND CONCLUSIONS

ACTH and cortisone afforded an effective means of combating the lightning pains of tabes dorsalis in a case where the usual means commonly employed were non-effective. The mobility of the Charcot joint was considerably increased while on these hormones.

ADDENDUM: After this paper was prepared for publication, Weiner and Mendelsohn reported corticotropin to be effective in treating a case of tabetic gastric crises.[4]

25 E. Washington St.

BIBLIOGRAPHY

1. Stokes, J. H. et al. Modern Clinical Syphilology. pp. 1011. W. B. Saunders Company, 1945.
2. Wagner-Jauregg, J. Uber die lanzinierenden Schmerzen der Tabiker. Wien. Klin. Wchnschr. **44**: 1509, 1924.
3. Orr, O. and Rows, R. G. Further Observations on the Influence of Toxins on the Central Nervous System. J. Med. Sci. **60**: 184, 1914.
4. Weiner, Alfred L. and Mendelsohn, Harry R. Tabetic Crises Treated. with Cortocotropin. J.A.M.A. **152**: 705 (June 20) 1953.

Erythema Multiforme Bullosum Following Phenylbutazone Therapy

Samuel M. Bluefarb, M.D. and Leonard Holt, M.D., Chicago

THERE are many reports of toxic reactions following phenylbutazone (Butazolidin) therapy, a drug administered for the treatment of rheumatoid arthritis and other rheumatic conditions. In one group studied[1], 321, or 40 per cent, or 800 patients showed untoward reactions and 121, or 15 per cent, had reactions of sufficient severity to warrant discontinuance of the drug. Among these patients, 5.6 per cent had associated cutaneous manifestations which, in most cases, consisted of nonpruritic macular lesions which faded readily. However, two patients developed bullous erythema multiforme which healed in three weeks' time. There was a tendency for the eruption to be more florid in areas exposed to sunlight. Eleven patients, or 24 per cent, of the 45 patients who developed an eruption, had a previous history of drug sensitivity. Twenty-two patients were able to resume or continue the medication without recurrence or persistence of the eruption while in three patients (6 per cent) resumption of therapy was not possible because of recurrence of the skin eruption.

The toxic reactions of this drug are of dermatologic interest since phenylbutazone therapy has been advocated for the treatment of psoriasis[2]. The two reactions of primary concern to the dermatologist are the cutaneous manifestations, which are probably of a hypersensitive allergic nature, and the hematologic reactions of agranulocytosis and thrombocytopenia. The cutaneous reactions consist of (1) morbilliform eruptions and urticaria, (2) erythema multiforme bullosum and (3) exfoliative dermatitis, while the symptoms associated with the hematologic reactions are (1) stomatitis and oral ulcerations and (2) purpura.

From the Department of Dermatology, Cook County Hospital and Northwestern University Medical School.

The incidence of morbilliform eruptions are mentioned by Kuzell[1], who noted two cases in his series. Other cases have been reported[2,3,4,5], including the fatal case reported by Nathan, et al[6]. Bullous erthema multiforme in a patient having a mucocutaneous ocular syndrome was described by Charet and Siegel[7] and a patient who developed exfoliative dermatitis, but subsequently recovered, was reported by Fishman and Reynolds[8].

Stomatitis may be manifested either by aphthous stomatitis, as a mucocutaneous manifestation of erythema multiforme bullosum, or in association with the agranulocytosis; in which case ulcerations may affect any portion of the oropharynx. Numerous instances of stomatitis have been reported and this symptom was a marked feature in the patient described by Heinz, et al[9]. Twenty-one patients (2.6 per cent) in Kuzell's[1] series had aphthous stomatitis of varying severity, not associated with leukopenia, while four women in this series had purpura in association with thrombocytopenia. The fatal case of thrombocytopenic purpura, reported by Feldman, et al[10], was a 61 year old woman who developed purpura on the legs and trunk.

A 30 year old Negress had received phenylbutazone medication in doses of 200 to 300 mg. per day at varying intervals during the year before admission. The only untoward reactions were soreness of the mouth and edema of the lips, on one occasion. One month before admission she developed pain of the legs and feet which increased in severity until she was unable to walk. Three days before admission she was given phenylbutazone, 200 mgm. a day. The following day she developed a sore throat, photophobia and soreness of the eyes, dysuria and a generalized maculopapular cutaneous eruption.

On admission she complained of pain of the legs and feet, sore throat and a generalized cutaneous eruption. Physical examination revealed the temperature to be 104 deg. F., pulse 140 per minute, respirations 18 and the blood pressure 110/70. The skin showed a generalized maculopapular eruption, the periorbital regions were edematous and the lips edematous and ulcerated, while a bilateral purulent conjunctivitis involved the eyes. The tongue and mucous membranes of the mouth showed a diffuse exudative inflammation with white patches on the pharyngeal wall. The lower extremities were edematous with extreme tenderness of the feet. The heart, lungs and abdomen appeared normal.

She was treated with penicillin, di-parlene, erythromycin, hydrogen peroxide mouth wash, glucophyline and zinc sulphate for the eyes. A temperature of 103 to 104 deg. F. persisted, and on the third hospital day a generalized bullous eruption appeared and a positive Nikolsky sign was elicited. (Figure 1)

She was then given 40 U ACTH intravenously in 200 cc of dextrose, 6 grams potassium chloride, one gram of terramycin and ascorbic acid daily, with local therapy consisting of 1:4000 potassium permanganate packs, followed by boric acid ointment (5 per cent), as well as general supportive measures. Her general condition improved with this therapy although a temperature of 99 to 100 deg. F. continued. On the sixth hospital day she was able to tolerate soft foods and fluids but because of a tendency to aspirate the fluids, the intraveneous feedings were resumed.



Figure 1. Bullous lesion of the skin.

She continued to improve and was able to take oral fluids on the eight hospital day. The intraveneous injections of ACTH were discontinued and she was given 40 U ACTH gel, twice a day, and the other medications were discontinued. The loosened skin of the hands and feet were sloughed in large sheets and several toe nails were shed. On the twelfth hospital day her temperature was normal but two days later she died. (Table 1)

TABLE 1: LABORATORY STUDIES

HEMOGRAM	*First (Admission)*	*Sixth*	*(Day of) Fourteenth (Death)*
Hemoglobin, per cent	76	94	85
Red Blood Cells, per cu. mm.	3,880,000		
White Blood Cells, per cu. mm.	3,450	9,450	12,100
Differential White Blood Cells:			
Polymorphonuclears, per cent	49		
Band Forms, per cent	23		
Lymphocytes, per cent	28		
URINE			
Albumin	4 plus		
White Blood Cells	"Many"		
BLOOD CHEMISTRY			
N.P.N., mg./100 cc		36	68
Creatinine, mg./100 cc			1.3
Fasting Blood Sugar, mg./100 cc		127	
Chlorides, meq./liter		98	96
Sodium, meq./liter		144	127
Potassium, meq./liter		4.4	7.8
CO_2, cc/100 cc			30
Total protein, mg./100 cc			6

On post mortem examinations there was a generalized maculopapular cutaneous eruption and isolated oval lesions, 1 to 3 inches in diameter, having a 1 to 3 cm. hyperpigmented erythematous border and a central lesion consisting of a collapsed bullae. The skin of the hands and feet had sloughed away leaving the surface red and raw. There were confluent, crusted lesions having a sero-purulent discharge, on the face and a bilateral, purulent conjunctivitis with adherent synechia between the eyelid margins.

The anatomical diagnoses were listed as:

1. Acute membranous tracheo-bronchitis
2. Pulmonary edema and congestion
3. Congestion of the gastrointestinal tract with ecchymoses around the rectum and sigmoid
4. Erythema multiforme with bullous lesions

SUMMARY

1. The cutaneous reactions occurring after phenylbutazone therapy are morbilliform eruptions including uticaria, erythema multiforme of the bullous type and exfoliative dermatitis.

2. Other symptoms of interest to the dermatologist are stomatitis, ulcers of the oropharynx and purpura; which may result from the agranulocytosis and thrombocytopenia.

3. The fatal case of a 30 year old Negress who developed severe bullous erythema multiforme following phenylbutazone therapy is reported.

Author's Note: A similar fatal case of erythema multiforms Bullosun due to the ingestion of phenylbutazone has been reported by R. B. Cone, C. A. Hannigan and R. Teicher in the A.M.A. Arch. Dermat. and Syph 69:674 June 1954.

REFERENCES

1. Kuzell, W. C., Schaffarzick, R. W., Naughler, W. E., Gaudin, G. and Mankle, E. A.: Phenylbutazone, A.M.A. Arch. Int. Med. **92**:615 (Nov.) 1953.
2. Steinbrocker, O., Berkowitz, S., Ehrlich, M., Elkind, M. and Carp, S.: Phenylbutazone Therapy of Arthritis and Other Painful Musculoskeletal Disorders, J.A.M.A. **150**: 1087 (Nov. 15) 1952.
3. Brandwein, S.: Agranulocytosis Following Phenylbutazone (Butazolidin), New York State J. Med. **53**:1577 (July 1) 1953.
4. Schwartz, N. H., Marshall, D. and Robinson, B. D.: Phenylbutazone Toxicity Resulting in a Severe Systemic Reaction, New York State J. Med. **54**:265 (Jan. 15) 1954.
5. Werblow, S. C. and Neber, J.: Agranulocytosis Following Phenylbutazone Therapy, J.A.M.A. **151**:1286 (Apr. 11) 1953.
6. Nathan, D. A., Meitus, M. L., Capland, L. and Lev, M.: Death Following Phenylbutazone (Butazolidin) Therapy: Report of a Case, Ann. Int. Med. **39**:1096 (Nov.) 1953.
7. Charet, R. and Siegel, I.: Unusual Reaction Following Use of Phenylbutazone (Butazolidin), J.A.M.A. **151**: 556 (Feb. 14) 1953.
8. Fishman, H. C. and Reynolds, J.: Exfoliative Dermatitis Following Ingestion of Phenylbutazone (Butazolidin), J.A.M.A. **153**:642 (Oct. 17) 1953.
9. Hinz, C., Lamont-Havers, R. W., Cominsky, B. and Gaines, L. M.: Agranulocytosis Following Use of Phenylbutazone (Butazolidin), J.A.M.A. **151**:38 (Jan. 3) 1953.
10. Feldman, L., Cohnen, F. and Hirsch, H.: Fatal Thrombocytopenic Purpura Following Phenylbutazone (Butazolidin) Therapy, Ill. Med. J. **105**:83 (Feb.) 1954.

Lung cancer

Bronchoscopy is not a young art. The use of a hollow tube to inspect the bronchial tree was described as early as 1897 by Killian. More recently, the work of Jackson, Clerf, and others has advanced the technic from that of a medical curiosity to a useful adjunct in the diagnosis and treatment of lung diseases. Formerly, bronchoscopy was limited largely to the removal of foreign bodies. In recent years, the use of this tool for diagnosis has increased. Yet even today there is no general agreement among the investigators as to the efficacy of this method of examination of the bronchial tree. Undoubtedly, many of you heard Dr. Alton Ochsner not long ago. He reported that in his clinic, bronchoscopic examination showed lung neoplasms in only 36 per cent of the cases examined. Other investigators have reported successful demonstration of lung tumors in up to 80 per cent of the cases bronchoscoped. *John B. Gregg, M.D., Lung Neoplasms From The Endoscopist's Standpoint. South Dakota J. Med. & Pharm., July* 1954.

Common accident hazards within the home

Slipping in the bath, tripping over toys and other objects and stubbing unshod toes are among the most common accident hazards in New York City homes, the Greater New York Safety Council reported recently on the basis of a spot check of 590,000 homes.

The report, based on an analysis of returns of last year's home safety inspection conducted public as police began today distribution to all the public elementary and high schools and to the Catholic schools of the Archdiocese of New by school children and their parents, was made York of home safety checklists which will be used in the 1954 inspections. Teachers will give out the checklists on November 12 to their pupils, who will take them home and join their parents in searching out and eliminating accident "booby traps."

This year's home safety inspection, for which 1,095,000 checklists (41,000 of them in Spanish) have been prepared and printed by the Greater New York Safety Council, is the eleventh annual. For the last six years the Council has been receiving from the schools summaries of returned questionnaires, after schools have completed their use of them for classroom discussions and community safety projects, and analyzed the returns. Of twenty questions on last year's checklist, the number of adverse answers to the following ten showed them to be in most common accident hazards, in this order:

"Is there a non-slip mat or heavy towel in the bathtub or shower to avoid falls?

"Do you put away all your clothes, toys and hobby materials as soon as you are through using them?

"Do you wear slippers or shoes at all times when walking in the house?

"Do you sit properly on chairs instead of tilting them back?

"Do you have pads or non-slip backing under small rugs and mats to prevent falls?

"Do you keep things out of your mouth which do not belong there — like pins, tacks, money, pencils?

"Is the window kept open at least two inches at all times while any gas appliance is in use?

"Do you always use a strong steady step stool or ladder when trying to reach high places?

"Is there a light of some kind near the bed so you need not walk and stumble in the dark?

"When you must spot-clean clothing and other articles, do you use only NON-FLAMMABLE cleaners which do not explode or burn?"

Mrs. Marjorie B. May, the Council's director of home safety, said the incidence of adverse answers varies from year to year among the twenty questions but in general the same hazards are near the top of the list. The three most commonly neglected hazards reported in the 1953 inspection have been among the top ten every year since the tabulations of replies began.

Although the wording of the questionnaire is changed and the order of questions shifts from year to year, the same hazards are noted repeatedly. The ten questions listed above as having brought, in order, the largest number of "No" responses had appeared in the 1953 checklist as, respectively, Questions Number 6, 18, 9, 20, 12, 17, 2, 14, 10 and 4.

The 590,000 inspection lists from which the summaries were made were those returned to the public schools. Some of the checklists are not brought back to school by pupils. The Catholic schools cooperate in giving the lists to their pupils and urging them to help their parents find hazards to be corrected.

‹ ›

Interesting aphorisms

Isaac Judaeus (A.D.c. 845-c. 940), an Egyptian Jew and physician to the rulers of Tunisia, was the author of books on diet, on fevers, on simple drugs, and on the urine. His collected works, printed in 1515, were greatly in demand as late as the 17th century, and he is quoted by Robert Burton (1577-1640) in the *Anatomy of Melancholy.* A number of pithy aphorisms are included in his *Guide for Physicians.* For example: "Ask thy reward when the sickness is at its height, for being cured, the patient will surely forget what thou didst for him." Another maxim is: "Should adversity befall a physician, open not thy mouth to condemn, for each hath his hour." A third runs thus: "Treating the sick is like boring holes in pearls, and the physician must act with caution lest he destroy the pearl committed to his charge." *Douglas Guthrie, M.D., A History of Medicine.*

EDITORIALS

The coronary personality

Many physicians have tried to describe the appearance, personality, and life habits of the man destined to develop angina pectoris and coronary thrombosis. Osler wrote: "It is not the delicate, neurotic person who is prone to angina but the robust, the vigorous in mind and body the keen and ambitious man, the indicator of whose engines is always at 'full speed ahead.' "

MacKinnon[1] found him to be the well set man of 45 to 55 with military bearing, iron gray hair, and florid complexion. His appearance is an amalgam of tension, profound anxiety, and wear and tear. He drives himself relentlessly most of his life and the signs of tension are burned into the personality and facial expression. The lined, haggard face makes him look older than his years.

Anxiety is part of the picture: many harbor fears, sorrows, and feelings of insecurity for years before symptoms of coronary disease develop. These emotional changes diminish coronary flow and disturb the tone of coronary vessels and the clotting mechanism of the blood.

Anxiety also is part of the postcoronary picture. Fear ranks with pain as the most common manifestation of coronary thrombosis. It usually outlasts other symptoms and is a major obstacle to complete rehabilitation.

At present, most research on the prevention of coronary thrombosis is aimed at controlling the lipoprotein and cholesterol particles in the blood and in the arterial walls. On the other hand, the frequent association between coronary disease and tension, stress, and anxiety suggests that psychiatric research also is indicated. MacKinnon believes "...the typical coronary personality often began to emerge in an early environment poor in material and emotional satisfactions. Temperamentally, they are somatotonics, individuals who derive pleasure from work, and often from little else."

They are . . . perfectionists and victims of an obsessional drive that gives them little rest or relaxation. They are unlike the average working man who is not ". . .unceasingly striving to better himself."

1. Alastar V. Mac Kinnon, M.D., The Life and Personality of the Coronary Patient. Univ. of Leeds, J., Oct. 1921.

Expensive medicine

The physician has the inalienable right to prescribe what he thinks best. But recommending a long period of recuperation may not be doing the patient a favor. It is easy to suggest another week off, an additional month at home, or a trip to Florida to regain strength for the few residual symptoms remaining after an acute illness. These symptoms usually disappear ultimately whether or not the patient is resting and they seldom are aggravated by work.

A myocardial infarct is an example. Healing is usually complete by the end of three months and in the absence of myocardial insufficiency it is doubtful whether additional rest will prove useful. Statistics show that the longer a patient stays away from work, the less chance he has of complete rehabilitation. Conversely, the man who gets back on the job in the average length of time is more likely to show progressive improvement.

Advising a patient not to work when his illness no longer justifies additional rest not only gives him the impression that he is seriously

ill but often proves expensive. A long convalescence reduces the patient's income and the efficiency of his office or business suffers. It also adds to the cost of the unemployment or disability insurance he carries. Futhermore, unemployment adds directly and indirectly to the burden of the community, of which the physician is part. Let's not be too generous with the other person's time.

Warren W. Furey — Gold Medalist

Physicians from all parts of the United States, Canada and Latin America met in Los Angeles for the 40th annual meeting of the Radiological Society of North America December 5-10.

On the evening of Thursday, December 9, Dr. Warren W. Furey of Chicago was the recipient of the Gold Medal award. Dr. Eugene P. Pendergrass, President of the Society, has sent the Illinois State Medical Society a copy of the citation which reads as follows:

"Among those who have selflessly given of time and effort that the fundamental principles of medical practice may become strengthened in this changing world is Warren W. Furey, M.D.

"A full biographic sketch regarding Doctor Furey's professional attainments, family, and diverse services in community affairs has been published in RADIOLOGY, February, 1950.

"We present here, certain aspects of Warren W. Furey's career for the particular benefit of those most recently entering radiology. Among Dr. Furey's activities is included service on committees of the Chicago Medical Society, secretaryship, and later presidency of that society; service as a delegate within the House of his State Society, and delegate to the American Medical Association representing the Illinois State Medical Society; secretary, vice-president, president and member of the Board of Directors of the Chicago Roentgen Society; president, and member of the Board of Directors of the Radiological Society of North America; membership on committees and commissions of the American College of Radiology, followed by service as treasurer and member of the Board of Chancellors of the College.

"Dr. Furey's interest and work as a member of the Board of Directors of the Blue Shield Plan of the Illinois State Medical Society lead to his secretaryship and presidency of the Illinois Blue Shield organization, followed by his becoming secretary of the Blue Shield Commission, and a member of its Executive Committee.

"It might be well to ask: How did Warren W. Furey attain the recognition these positions illustrate?

"First and foremost, Warren W. Furey has a tremendous innate and genuine desire to serve others. Coupled with this is a knowledge, possessed by few, of the problems facing American medicine in general and radiology in particular. This is solidly based on years of study and service. He has a genius for friendship and an organizational flare.

"To radiologists Dr. Furey's status and position mean that the point of view of the practicing clinical radiologist will be present in the highest councils. He is in a position to press the legitimate claims and aspirations of radiology at the top level. Standing where he does, with the men who control the destinies of American medicine, his wisdom is recognized and becomes effective. He is our ambassador, and the Board of Directors and the members of the Radiological Society of North America are very happy to present to him, the Gold Medal of the Society."

The members of the Illinois State Medical Society also desire to express appreciation to Warren W. Furey for the sustained and loyal interest he has always expressed and exemplified as a friend, a practicing physician and a member of his county and state association.

The passing of Fred H. Muller, M.D.

Fred H. Muller of Chicago, died at the Presbyterian Hospital on November 23, 1954. Dr. Muller was well known to most of the members of the Illinois State Medical Society in which he has had many important roles over some period of time. For two years he acted as General Chairman of the Committee on Arrangements for the Society's annual meeting, and was first Vice President for two consecutive years.

For a number of years he was one of the Society delegates to the American Medical Association, and was a regular attendant at these sessions. Dr. Muller was a Past President of the Chicago Medical Society to which organization he also devoted a great deal of his time over a period of many years.

Dr. Muller was graduated from the Loyola University Medical School in 1909, and while conducting a general practice, gradually fitted himself for pediatric work. The delegates to the A.M.A. from Illinois, introduced a resolution before the House of Delegates at the recent Miami meeting memorializing Dr. Muller, which was immediately passed by a standing vote. The many friends of Fred Muller will miss him, and will join with the A.M.A. House of Delegates, and the Council of the Illinois State Medical Society in their expressions of sympathy to Mrs. Muller and other members of the family.

‹ ›

AMERICAN MEDICAL ASSOCIATION
House of Delegates
RESOLUTION

Introduced by: Illinois Delegation
Illinois State Medical Society
Subject: Death of Fred H. Muller, M.D.

Whereas, Dr. Fred H. Muller, a member of this House of Delegates from the Illinois State Medical Society, has served faithfully for many years; and

WHEREAS, His untimely death on November 23, 1954 has deprived this House of Delegates of his services and saddened his many friends; be it

Resolved, That this House of Delegates spread on the record of this meeting an expression of sympathy and forward to his wife and family a copy of this resolution.

‹ ›

Edmund Brewer Montgomery 1858——1954

Dr. E. B. Montgomery of Quincy, known to many physicians throughout the nation, passed away at St Mary Hospital, Quincy, December 8, 1954. Dr. Montgomery in his 97th year, had completed 76 years of practice, and only retired from his long professional career a few weeks before his death. Dr. Montgomery was born in St. Louis, and the family moved to Quincy when he was a small boy.

He attended Jefferson Medical College in Philadelphia, graduating from that institution in 1878. He returned to Quincy for practice. He took a number of post graduate courses in the United States, as well as in several European centers. He was a charter member of the American College of Surgeons, and rarely missed an annual meeting of that organization. In making long trips to medical meetings on the East or West Coasts, he would usually go by air, and this continued until the past two years.

He was the author of many articles published in medical journals throughout the nation, and he was a faithful member of many organizations, medical, surgical and civic. In 1953 he was honored by his own alma mater when he was acclaimed their oldest living alumnus, and was given a Doctor of Science degree. The American Medical Association also has considered Dr. Montgomery the oldest member of that organization in years of service, and continuous membership.

He was a regular attendant at the annual meetings of the Illinois State Medical Society and was always present at the luncheon of the Fifty Year Club. Surviving this fine doctor, are two sons and three daughters, three grandchildren and two great-grandchildren.

Many members of the Illinois State Medical Society have been intimately acquainted with Dr. Montgomery over the years, and will unite in sending their expression of sympathy. At the meeting of the Council of the Illinois State Medical Society held on December 12, a resolution in respect to the memory of this physician was unanimously approved and will be sent to his family.

‹ ›

1955 Illinois March of Dimes against polio

The polio attack rate in Illinois last year according to provisional reports was about the same as the national average for the year 1954. Nationwide, the number of cases reported in 1954 was the third highest on record.

The highest polio epidemic year in Illinois during recent times was in 1952, when 4,002 polio cases were reported. This was 20 percent higher than the national average for that year. It is impossible to predict when and where polio epidemics will strike, which underlines the need for more effective control measures.

Evaluation of the Salk vaccine, administered to 440,000 U.S. children, in the largest medical experiment of its kind ever conducted, is now in progress. Announcement of the vaccine's effectiveness will be made in the Spring of 1955.

During the field trials last Spring about 14,000

children in the state of Illinois were inoculated half with the Salk vaccine, half with a placebo.

It is hoped that Illinois physicians will support the 1955 March of Dimes as enthusiastically as approximately 20,000 physicians throughout the United States cooperated in the 1954 vaccine field trials sponsored by the National Foundation for Infantile Paralysis.

This year the March of Dimes must do a bigger job than ever before. It must raise $64,000,000 — because $9,000,000 is needed to purchase vaccine, $2,700,000 for scientific research, $2,900,000 for professional education, and at least $29,900,000 for patient aid, including hospitalization. The March of Dimes has expended $203,500,000 in patient aid since 1938.

For science and humanity, give generously to the 1955 March of Dimes in January. Let your patients and friends know that the March of Dimes fights wisely, economically and effectively against the polio threat.

‹ ›

Television in postgraduate medical education

The Council on Medical Education and Hospitals of the A.M.A. is planning a program on the subject of "The Potential Use of Television in Postgraduate Medical Education" to be presented as a full-day working conference on February 5, 1955, in the Ballroom of the Palmer House Chicago. This is expected to be the first of a series of annual "workshop" type conferences on one particular aspect of postgraduate medical education.

Television is the subject of the first meeting because of the extreme interest in this medium that has been shown recently, as well as its pertinence to the future of postgraduate education. The program is planned in such a way as to present both the educational and technical aspects of the subject, so that medical educators and medcial society, hospital and specialty society representatives at the meeting will be able to obtain a broad picture of the medium and help them to determine whether or not it is something they might use in their own programs, and if so the problems involved in its use.

Following a keynote address by Dr. John Cline, the morning session will be devoted to considerations of the purely educational aspects of the medium. The afternoon session will deal with technical considerations and financing. The participants will be drawn from the fields of general education, television, industry, medicine, medical education, pertinent government agencies and others. It is planned to have a number of demonstrations in the afternoon session using actual camera chains and receiving equipment. Following the session it will be possible for the audience to examine these and observe some of them in further action, and visit a local television station in action.

‹ ›

Doctors will get isotope know-how in new courses

Use of radioactive isotopes in biology and medicine will have increased attention in courses to be sponsored jointly by the Northwestern university Medical school and the Argonne National laboratory.

The vital place of such materials in research, diagnosis and therapy will be brought to medical students and graduate physicians through instrution in a field formerly open only to physicists and radiologists.

The effort was accelerated early this year in a conference of Midwest educators, and representatives of the Atomic Energy commission, Oak Ridge Institute for Nuclear Studies, Brookhaven National laboratory, Veterans administration and the National Institutes of Health.

Dr. John A. D. Cooper, director of Northwestern's isotope unit, and Austin M. Brues, director of biological and medical research at Argonne, discussed the problems involved in the November issue of the Journal of Medical Education.

Overall planning, it was explained, is aimed at impressing the student with the fact that radioisotopes are not esoteric, mysterious agents understood by a chosen few, but useful materials for use in at least some areas of practice by those physicians who will master their peculiarities.

Five classes of individuals were considered: the undergraduate medical student, the physician who wants the knowledge but who does not wish to become proficient in using isotopes, the physician who wishes to be certified in use of two or three for well established diagnostic or therapeutic procedures, the physician who wants to qualify to use isotopes in a variety of

purposes, and the radiologist interested in teletherapy.

An orientation type of program was approved for the first two, and there was little disagreement on education and training for the others except in the instance of physicians who wish to use radioisotopes in established procedures for diagnosis and treatment.

The undergraduate would be given understanding of trends in the field, a basis on which he could build as far as interest and ability permit. Much could be imparted in preclinical and clinical years, presenting aspects which fall naturally within his subject matter. He would not be trained in actual use of the materials.

Greatest need is for programs allowing physicians to come and work with radioactive materials, Dr. Cooper said. Possible hazards to patients from their improper use caused much concern in forming these training courses. Considerable study in elementary nuclear physics, instrumentation, radiobiology, handling techniques and health protection would be needed. Apprenticeship with a group actively using the isotopes is considered essential to develop clinical judgement.

Participants in the conference agreed that standards for education and training should continue to be elaborated by the Subcommittee on Human Applications and that the Atomic Energy commission assure itself of conformity with set requirements before granting authorization for the use of radioisotopes.

It was generally understood also that none of the training programs appeared to be the responsibility of government.

‹‹‹ ›››

Treatment and miscarriage

One of the apparent errors in interpreting the results of any treatment of threatened abortion is that many physicians believe the high percentage of results so often reported in patients who carry a pregnancy to term after one miscarriage is due entirely to the treatment. Actually, the results without treatment are 75 to 80 per cent. Malpas has shown that after a woman has lost one baby, 78 per cent can have a normal pregnancy; after losing two babies, 62 per cent; after losing three babies, 27 per cent; and after losing four babies, only 6 per cent could be expected to carry a pregnancy to term. *Karl John Karnaky, M.D., The Use of Micronized Vitaminized Stilbestrol in Severe Threatened Abortion. Arizona Med., July* 1954.

Cortisone and arthritis

A Hench survey of his cortisone results in 216 cases of rheumatoid arthritis over a three year period shows that they are only half perfect but 51 per cent with marked or very marked relief is very markedly good. Hydrocortisone (compound F) has the same effect but is more potent per mg . . . . . Kammerer and Cecil suggest that cortisone be used chiefly for fulminating juvenile cases, for aged cases which have begun late, and for ankylosing spondylitis. X-ray therapy also may be used in the third group. I'll bet that in this day and age it is as hard to keep cortisone away from any kind of arthritis as it is to keep food from a fat person. Guillermo Osler, M.D., RX., DX., And Drs., Arizona Med., July 1954.

MEDICAL ECONOMICS

John R. Wolff, Chairman, Walter C. Bornemeier, Edward W. Cannady, Roland R. Cross, Jr., E. F. Dietrich, W. W. Fullerton, Edwin F. Hirsch, Frederic T. Jung, W. R. Malony, Caesar Portes, William Requarth, Frederick W. Slobe.

General Practice

W. W. Fullerton, M.D., Sparta

THE following article is written primarily to stimulate concern over the future of medicine and the type of medical practice to be expected in future years. It is not the intention of the author to write a sob story about the financial status nor the loss of prestige of the present day general practitioner. The greatest difficulty in specialty practice where there is no referring personnel, such as a general practitioner to direct patients, is that patients will shop from one specialist to another before finding the one he should have been directed to first. There is no intention of antagonizing the specialist nor to interfere with the choice of specialty by medical students and internes. However, it is the opinion of the writer that specialists should be doctors first then specialists; they should learn how other people live, and understand their problems, economic, social, financial, racial, religious and all the things that go into the makeup of people's personality. The best way to learn this is general practice. The proposals brought out in this article will be met with opposition by many because of its controversial issues. It would be interesting to make a survey of all the general practitioners in the United States and tabulate as to whether they are satisfied with being in general practice; how many of them would like to be a specialist and what specialty it would be. Some, at least, would go into a speciality, if they could be relieved of their present position and were eligible for specialization.

The most serious thing that could happen to America Medicine and Medical Organizations would be a complete breach between the general practitioners and the various specialties or the elimination of the general practice entirely. This may appear to be an idle thought. However, the fact that the general practitioners of the nation have joined together and formed an Academy of General Practice is evidence that there is apparently some dissatisfaction among the general practitioners because of the economic pressure that has been exerted upon them by the ever-increasing number of specialists in all branches of medicine. The most valuable asset that the Academy of General Practice has offered has been the stimulation of an the improvement of the knowledge of the general practitioners and thus making them more qualified to do the work that they want to do. The general practitioner formerly was the man who saw the patient first. He took care of his patients and often was the only physician who saw them from the time of birth to the time of death. When the general

practitioner was honest with himself and honest with his patients, he recognized the fact that there were situations in which he needed help and he appreciated receiving advice from men who had developed a particular skill in some phase of the arts and sciences of medicine. These men, who had developed and become especially adapted to certain types of work, then began more and more to limit their practice to such special type of work; this was the beginning of specialization.

However, in the old days this specialist was a man of extensive experience. He was a man who had been in general practice, he had seen the whole field and realized what the art of medicine was and what a complex mechanism the human physiology and human pathology presented. He knew the family background; he also knew the patient as an individual. He knew many patients in such ways and could treat intelligently as he became more and more specialized because he had received training through hard work and study.

It became noticeable to other specialists that some were better than others. They developed societies in which only men doing this or that type of special work were eligible to join. The specialists then developed certain criteria by which a doctor could become a specialist. Thus by evidence of proficiency, evidence of further study, and evidence of limiting his work to the specialty, he became a specialist. The field began to get crowded and they raised their standards. A doctor could become a specialist by becoming associated with a specialist, in the specialist's office, or he could become a specialist by serving a residency over a prescribed period of years and thus by evidence of his intelligence and proficiency would become a member of a special board.

The general practitioners then ceased to be teachers in medical schools since there were specialists available to do this teaching and it was deemed they could do it more efficiently than a general practitioner. The medical student came to the end of his academic years, he honored and respected his teachers as he should, and wished to follow in the footsteps of one of them. Therefore, he directed his aims, his training, and his thinking to becoming a member of that speciality. If he could avoid entering into general practice he could save years in reaching ultimate goal. Thus we have men today with boarded specialist's rating who probably couldn't take a decent history and know little about the individual outside of their own speciality. Yet they assume stature above the general practitioner who may be their senior by many years of contact with the medical arts and sciences.

The field in the metropolitan areas became crowded with specialists. A group of specialists decides that this or that general practitioner should not be doing certain types of work. It is decided that the general practitioner should not do any work that a specialist can do.

The next thing in the continued procedure is that the general practitioner in some hospitals can not be on the staff and can not admit patients under his service, as he does not have a service; and gradually it becomes apparent that in a few short years the general practitioner will not be able to go in and out of the hospitals and will be eliminated from hospital practice.

The easiest way out in the depression years was for the young doctor to go to the rural areas. At least, he could get his potatoes and meat in the country. When the depression was over fewer doctors went to the country. The hard work of rural practice and the encroaching of the specialization into the hospital work was discouraging. The specialists are now moving to the smaller towns because of overcrowding in the city. Therefore, we are faced in a few short years with the possibility of complete specialization; if it is not complete specialization, the general practitioner will only have offices as collecting stations in order to refer work to his favorite group of specialists; he himself having no more prestige in his community than a first year interne in a hospital.

The paradox in all this specialization is that the specialists are anxious that men go into general practice. However, the young medical student is not stupid either. He doesn't want to be a general practitioner and work hard and sweat, make a five dollar house call for an acutely inflamed appendix and then see his former classmate get one hundred and fifty dollars for removing the appendix. Therefore, the medical students do not have the incentive

to become general practitioners as their fathers had. Their teachers are specialists; the specialists get big fees while the general practitioner gets little fees. The medical student, in his addition, figures that he has spent this much on his medical education; why not spend a few more dollars and a few more years and be a specialist? It would be foolish to stop formal academic training now.

What will be the economic result of complete specialization? It will simply mean that the medical profession will price itself out of the reach of the rank and file of average citizens. The rank and file of the population as a whole cannot pay specialist's fees for every medical service they demand. Therefore, the cry for government-supported medicine will increase. The increase in specialization and the decrease in the desire of our young men to become general practitioners will widen the breach and raise the cost of medical care; we will lose our battle against socialization because we priced ourselves out of the field.

What can be done about this situation? Does it even deserve consideration or shall we let economic events take their course and surrender to government control a profession that has always contained itself and solved its own problems? We may not be able to solve the problem; there may not be any solution. However, it seems as though we should make an attempt.

Here is one possible solution. It is not a new idea. That is, after a medical student has completed his internship, and has received his degree of Doctor Medicine, that he be required to go into general practice for at least three years, and let him develop the art of medicine and find out what particular skill is easy for him to develop. It might even be that he may prefer to stay in general practice. If he preferred to be a specialist then he could choose wisely what specialty he should go into. It is not inconceivable that he might even change his notions as to what specialty he wants to take up. This plan has its objections in that it would increase the infancy of his medical career and prolong his medical training period. However, it is the writer's opinion that it would not actually be time lost; if he is a true student of medicine, his period of learning should not stop the minute he gets his board of specialization anyhow, so what difference does it make if he had lost three or four years in achieving his ultimate goal in life? If he achieves his ultimate goal in life, he continues to study long after he has passed his board of specialization. If he does not do that then he has missed his mission in life. The same can be true of general practitioners. The general practitioner who does not study and strive to improve himself has also missed his mission in life. The general practitioner is an energetic man if he is successful. He has certain qualifications, he has a family to support, he also should be allowed to bear a little prestige in the community in which he serves. He too should be respected as a man of the profession.

The above mentioned plan of course is not the last word nor the only possible suggestion that is available for solving this problem. Another alternate possibility would be to "farm out" students in the summer months or in his fourth year of medical school to general practitioners who are working particularly in the rural areas. There is no doubt but what this could be of a great deal of value to a medical student in helping him to see the advantage of general practice particularly rural practice.

This brings up a question of just what is wrong with the man of today. The writer thinks it applies to the medical profession as much as it does to anyone else. Every American wants to be a big shot, and if everyone is a big shot nobody is left to do the work.

Any plan that is devised or used to encourage young doctors into going into general practice should first be directed towards showing the young men the advantage of this type of experience. Briefly; the economic return, his prestige in the community, association with the people he works for, his independance, his freedom from taxing social obligations. However, it may be up to the various boards of specialists to get together and devise some sort of prerequisite for their candidates; qualifying them in reference to experience and time in general practice.

CORRESPONDENCE

Clinics for crippled children listed for February

Twenty one clinics for Illinois' physically handicapped children have been scheduled for February by the University of Illinois Division of Services for Crippled Children. The Division will count 14 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examinations along with medical social and nursing services. There will be 5 special clinics for children with rheumatic fever and 2 for cerebral palsied children.

Clinics are held by the Division in cooperation with local medical and health organizations, both public and private. Clinicians are selected among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or may want to receive consultative services.

The February clinics are:

February 2 — Hinsdale, Hinsdale Sanitarium

February 3 — Litchfield, Madison Park School

February 8 — Peoria, Children's Hospital

February 8 — East St. Louis, Christian Welfare Hospital

February 10 — Springfield, St. John's Hospital

February 10 — Elmhurst (Rheumatic Fever), Memorial Hospital of DuPage County

February 10 — Tuscola, Veterans of Foreign Wars Bldg.

February 11 — Chicago Heights (Rheumatic Fever), St. James Hospital

February 15 — Vandalia, American Legion Building

February 16 — Chicago Heights, St. James Hospital

February 16 — Carrollton, Carrollton Grade School

February 17 — Rockford, St. Anthony's Hospital

February 18 — Macomb, Marietta Phelps Hospital

February 22 — Peoria, Children's Hospital

February 22 — Effingham (Rheumatic Fever), St. Anthony's Hospital

February 23 — Alton (Rheumatic Fever), Alton Memorial Hospital

February 23 — Springfield (Cerebral Palsy), Memorial Hospital

February 23 — Elgin, Sherman Hospital

February 24 — Bloomington (General and Cerebral Palsy), St. Joseph's Hospital

February 24, Anna, New City Hospital

February 25, Chicago Heights (Rheumatic Fever), St. James Hospital

Tenth National Conference on Rural Health

The Tenth National Conference on Rural Health will be held at the Hotel Schroeder, Milwaukee, Wisconsin, February 24—26, 1955. This conference as usual, will be presented by the A. M. A. Council on Rural Health. In addition to an excellent program additional time will be available for discussion and audience participation.

Among the subjects to be presented, are Accident Prevention and Family Responsibility in Health Affairs. An informal pre-conference session for members of the medical profession will

be held at 10.00 A. M., Thursday, February 24. This session will be devoted to discussions pertaining to the Medical Association's committees handling rural health activities. At this session particular emphasis will be placed on citizen responsibility and training for rural practice.

Further details and a complete program relative to this interesting conference may be procured by writing to the Council on Rural Health, American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois.

‹ ›

Postgraduate course on diseases of the chest

The Council on Postgraduate Medical Education of the American College of Chest Physicians, in cooperation with the respective state chapter of the College as well as the staffs and faculties of the local hospitals and medical schools of Philadelphia, will sponsor the Eighth Annual Postgraduate Course on Diseases of the Chest, to be held at the Bellevue-Stratford Hotel, Philadelphia, Pennsylvania, March 7-11, 1955.

Our postgraduate courses endeavor to bring physicians up to date on recent advancements in the diagnosis and treatment of heart and lung disease. Tuition is $75.

Further information may be secured by writing to the Executive Director, American College of Chest Physicians, 112 East Chestnut Street, Chicago 11, Illinois.

‹ ›

Annual Conference on Medical Education and Licensure

The Annual Congress on Medical Education and Licensure is conducted under the auspices of the Council on Medical Education and Hospitals of the American Medical Association, the Federation of State Medical Boards of the United States and the Advisory Board for Medical Specialties.

The following open meetings constituting the Congress on Medical Education and Licensure are called to your attention at this time:

Saturday, February 5, 1955, 9:00 a.m. to 5 p.m., Special Program in Postgraduate Medical Education: "The Potential Use of Television in Postgraduate Medical Education".

Sunday, February 6, 1955, 9:00 a.m. to 12:30 p.m., Open Meeting of Advisory Board for Medical Specialties.

Sunday, February 6, 1955, 2:00 to 5:00 p.m., Open Meeting of Federation of State Medical Boards.

Monday, February 7, 1955, 9:00 a.m. to 5:00 p.m., Council on Medical Education and Hospitals — Highlighting Legal and Forensic Medicine in undergraduate medical education, the future status of the internship in the program of medical education, etc.

Monday, February 7, 1955, 7:00 p.m., Federation Banquet.

Tuesday, February 8, 1955, Federation of State Medical Boards of the United States.

‹ ›

Lectures and discussions on current medical problems

The Mayo Clinic and Mayo Foundation announce a 4-day program April 19-22, 1955, inclusive, of lectures and discussions on problems of current interest in the general fields of medicine and surgery. The number of physicians and surgeons who can be accommodated is necessarily limited. Those wishing to attend should communicate with Dr. N. W. Barker, Mayo Clinic, Rochester, Minnesota, before March 1, 1955. Applications will be honored in the order in which they are received. There is no registration fee.

‹ ›

New Ciba-sponsored weekly television program on medical research

A new network television program which will present the latest news of advances in medical and pharmaceutical research was premiered on Sunday evening, December 12th over ABC-TV under the sponsorship of Ciba Pharmaceutical Products, Inc., Summit, N. J.

Called "Lifeline", the new program is a dramatic-documentary series designed for the physician and the interested layman audience. It will been seen on 14 stations on Sunday at 8:15 to 8:30 P.M. Central Standard Time and in two cities with delayed Kinescope telecasts.

Narrator of "Lifeline" will be Dr. Louis H. Bauer, past president of the American Medical

Association, Secretary-General of the World Medical Association, and Chairman of the United Medical Service.

"Lifeline" will be presented with the cooperation of the American Medical Association and will be seen in Chicago on WBKB and Milwaukee on WTVW.

Ciba is the first ethical pharmaceutical company to present on open-circuit a network television weekly series of this type.

‹ ›

A date to remember

Attendance at the 1955 Clinical Conference of the Chicago Medical Society should be a *must* on your schedule. Set aside four days — March 1, 2, 3 and 4, 1955 for valuable postgraduate observations in the great medical center of Chicago.

The Program Committee has made every effort to select papers of immediate value to both the general practitioner and specialist.

This year the practical demonstrations will again be emphasized. Outstanding men will show actual patients illustrating problems in fractures, gynecology, neurology, ophthalmology, x-ray interpretation and other topics.

Twenty-four original papers dealing with current problems will be presented by some of the foremost medical authorities and educators. Color television on many interesting subjects will be shown daily during the Conference. There will be a carefully chosen series of scientific and technical exhibits of the latest research results and new products.

The completed program will be published within a few weeks. Meantime put a ring around these dates and make your reservation direct to the Palmer House which will be the headquarters for the 1955 Clinical Conference.

‹ ›

U.S. Civil Service Commission positions

The U. S. Civil Service Commission has announced that applications are now being accepted for Medical Officer for filling the following trainee positions in St. Elizabeths Hospital in Washington, D. C.: rotating intern, $2,800 a year, and a resident-in-training in psychiatry and in neurology, $3,400 to $4,200 a year. Appointments will be open July 1, 1955.

Applicants for the intern positions must be fourth-year students in an approved medical school. For the resident positions, applicants must be graduates from an approved medical school with the degree of doctor of medicine and in addition must have completed a full year's internship or now be serving such internship. No written test is required. The age limit of 35 years will be waived for persons entitled to veteran preference. Full details concerning the requirements is given in examination announcement No. 429 (B).

Applications will be accepted until further notice by the Board of Civil Service Examiners, St. Elizabeths Hospital, Washington 20, D. C. Further information and application forms may be obtained from most post offices or from the U. S. Civil Service Commission, Washington 25, D. C.

‹ ›

Plans set for CME's 1955 convention in Los Angeles

Outstanding lectures, panel discussions, and luncheon panel meetings, along with refresher courses, scientific and technical exhibits, and women's activities, will be featured at the 1955 Alumni Postgraduate Convention in Los Angeles next February 15 to 17, Dr. William F. Quinn, General Chairman of the Convention's Governing Board, has revealed.

The three-day convention, sponsored by the Alumni Association of the School of Medicine of the College of Medical Evangelists, is open to all physicians regardless of their school affiliation. Usually around one-third of the physician registrants are non-CME graduates. The Convention is geared primarily to the needs of general practitioners.

The Scientific Assembly meeting from Tuesday through Thursday at the Biltmore Hotel, is preceded by two days of refresher courses on the CME's Los Angeles campus at the White Memorial Hospital. These courses are also planned primarily for general practitioners and are open to all physicians.

Requests for information about the 1955 APC should be addressed to the Managing Director, Walter B. Crawford, at 316 North Bailey Street, Los Angeles 33, California.

NEWS of the STATE

ADAMS

Society News.—The regular monthly meeting of the Adams County Medical Society was held at the Lincoln Douglas Hotel Monday night, Nov. 8, preceded by a dinner in honor of the speaker, Dr. Frank D. Shobe of St. Louis, Instructor in Clinical Psychiatry, Washington University School of Medicine. Dr. Shobe talked on "Psychiatric Care" and related some of the problems involved in the treatment of many mentally ill patients. Dr. Shobe related the difficulties involved in organizing a Mental Hygiene Clinic in a small community which does not have a resident psychiatrist.

At the business session, Dr. Orville Graves, Jr., and Bruce K. Johnson of Quincy were elected to membership in the Adams County Medical Society. Dr. Walter Stevenson, Chairman of the Nominating Committee, reported the nominating of officers for 1955.

CLINTON

Society News.—At a meeting of the Clinton County Medical Society in Breese, November 10, Drs. William F. Rose and F. D. Bihss discussed radioactive isotopes.

COOK

Changes at State Hospital.—Dr. Kalman Gyarfas, clinical associate professor of psychiatry, University of Illinois College of Medicine, has been named superintendent of the Chicago State Hospital. Other appointments include Drs. W. M. C. Harrowes, clinical director of research and education; Dr. John Cowen, assistant medical superintendent; Dr. Ladislas J. Meduna, psychiatry consultant; Dr. Rudolph G. Novick, psychiatry consultant; Dr. R. A. Fisher, resident chest physician; Dr. Joseph D'Silva, resident chest surgeon, and Miss Freida Axen and Miss Catherine H. Hitchcock, chief nurse and assistant chief nurse, respectively. John T. Taylor, former army colonel on Gen. Douglas MacArthur's war time staff, was named to fill a newly created position of assistant non-medical superintendent. Dr. Duncan Campbell, who had been acting superintendent, retired after eleven years service with the state.

New Research in Rheumatic Fever.—The Samuel Sackett Foundation, established recently for scientific research, has selected as its first project an investigation of rheumatic fever and its related diseases.

The research will be conducted in Northwestern University's medical school. Studies will be supported by income from the $500,000 foundation created by Mr. and Mrs. Samuel J. Sackett, of Evanston, and their daughter, Mrs. Elizabeth Sackett Crocker, of Houston, Texas.

Foundation trustees are Mr. Sackett; Frank T. Murray, Chicago attorney, and Dr. Lowell D. Snorf, Northwestern professor of medicine, who resides in Wilmette.

Laboratory facilities for the studies will be provided in the new Morton Medical Research building, scheduled for completion in April at the Northwestern Medical Center on the University's Chicago campus.

The project will be directed by a senior investigator, yet to be appointed, within the medical school's department of medicine.

A broad and containing investigation is planned, rather than any specific study related to a limited aspect of rheumatic fever. Thus it is hoped to develop a cohesive and imaginative research program which will furnish a background for specific studies.

The project has not been limited entirely to rheumatic fever, as this disease encompasses many fundamental medical disciplines. The approach will be broad enough so that the tenuous path of research from rheumatic fever to heart disease, for example, could logically be followed.

In explaining his purpose in supporting the research, Mr. Sackett stated that "rheumatic fever leads to heart disease, and heart disease is our number one killer, far outdistancing polio or cancer. Yet because it is less dramatic, far less is being done to conquer it. I am pleased that the North-

western University department of medicine will now be be able to undertake research in this field."

More than a million Americans are afflicted with rheumatic fever. The disease strikes hardest at the young. A major cause of heart disease in adults, it is the principal cause of death in the 5 to 19 age group and second ranking cause of death in the years 20 to 24.

Mr. Sackett, of 2430 Orrington, is a member of the Northwestern University Associates, an organization of business and civic leaders interested in the University. His daughter resides at 3257 Huntingdon pl. in Houston.

Faculty Changes.—Dr. John J. Sheinin, president of the Chicago Medical School has announced the following appointments: To the department of surgery, Drs. Nathan N. Crohn, Samuel L. Goldberg, Alfred W. Kneucker, Charles A. Schiff, Bernard Stodsky, and Samuel Perlow; to the department of neurology and psychiatry, Dr. Alexander Rilkevitch; department of medicine, Dr. Epigniew Laprus. Promotions went to Dr. Irving Mack in the department of medicine; Dr. Milton Eisenstein, department of surgery, and Dr. Samuel I. Kaufman, department of ophthalmology.

Professor Hunt Gives Salmon Lectures.—Prof. William A. Hunt, chairman of Northwestern University's psychology department, delivered the Thomas W. Salmon lectures before the New York Academy of Medicine on December 6, 8 and 9.

His subject was the role of the clinical psychologist in the study and treatment of mental illness.

It is the first time since the lectureship was established in 1932 that the honor has been extended to a psychologist. Most lecturers, chosen by an Academy committee on psychiatry and mental hygiene, have been selected from the fields of psychiatry and neurology.

The only other exceptions have been Prof. Harold D. Lasswell, Yale University political scientist, who delivered the lectures in 1947, and the late Prof. Ralph Linton, Yale anthropologist, who lectured in 1953.

A fellow and former board member of the American Psychological Association, Prof. Hunt is a consulting editor of the Journal of Clinical Psychology, the Journal of Consulting Psychology and the Journal of Abnormal and Social Psychology.

Paul Bucy Joins Northwestern.—Dr. Paul C. Bucy has joined the faculty of Northwestern University's medical school as professor of surgery, it was announced by Dean Richard H. Young.

Dr. Bucy since 1941 has been professor of neurology and neurological surgery at the University of Illinois. From 1928 to 1941 he was a faculty member at the University of Chicago medical school, where he headed the division of neurology and neurological surgery. During 1953 he was visiting professor of surgery at the University of Indiana.

A graduate of the University of Iowa medical school, Dr. Bucy is the author of several books and numerous articles in professional journals. He is a member of the Society of Neurological Surgeons, the American Surgical Association, the International Surgical Society, the American Physiological Society, the American Neurological Association, and the American College of Surgeons.

Society News.—Dr. Willis J. Potts gave the presidential address at the thirty-ninth annual meeting of the Institute of Medicine of Chicago, December 6; his subject was "Children Cry."

DU PAGE

Physicians Discuss Formation of Auxiliary.—Fifty physicians and their wives devoted the regular meeting of the DuPage County Medical Society, November 17, to discuss the possible formation of an auxiliary. Guest speakers were Mrs. Albert Kwedar, Springfield, president of the Woman's Auxiliary to the Illinois State Medical Society; Mrs. Warren Young, Chicago, president-elect, and Mrs. Earl Liembacher, Joliet, Councilor for the Eleventh District which includes DuPage County.

Membership Booklet.—The DuPage County Medical Society has available a convenient booklet of its membership, classified according to towns. In addition, the individual members are "keyed" to show their particular field. The booklet also shows its Fifty Year Club members, members in armed forces and past service or retired members.

Tips for Getting a Doctor.—Timely tips for obtaining a physician in an emergency were published in the DuPage Press, November 27, based on an interview with Dr. Samuel K. Lewis, secretary-treasurer of the DuPage County Medical Society. Any one needing a physician should call the county medical society for the names of several; once a physician is obtained, all numbers where he can be reached should be kept at the telephone. In ar emergency, don't call a specialist, Dr. Lewis warned; instead let your family physician select one for you. In connection with the story, the names and addresses of several general practitioners in the area were published for the benefit of newcomers.

KNOX

Election of Officers.—Dr. Charles Paisley is the new president of the Knox County Medical Society; other officers chosen at the November 19 meeting are Drs. Kenneth Smart, vice president, and Fred Stansbury, secretary-treasurer. Dr. Orville E. Gordon, associate professor of ophthalmology, Northwestern University Medical School, Chicago, addressed the Society on "Common Eye Disorders."

MACON

Society News.—"Anemia in Children" was discussed by Dr. C. J. Harrison, St. Louis, before the Macon County Medical Society, November 23, at the Decatur Club. Dr. Harrison is professor of pediatrics at Washington University School of Medicine.

MADISON

Society News.—Dr. C. M. Christensen, Springfield addressed the Madison County Medical Society at St. John's Methodist Church, Edwardsville, December 2, on "Replacement Transfusion in Erythroblastosis."

SANGAMON

Dr. Schuman Goes to Minnesota.—Dr. Leonard M. Schuman has resigned as deputy director in charge of the division of preventive medicine of the Illinois State Department of Public Health to become affiliated with University of Minnesota School of Public Health. No arrangements have been made to fill the vacancy left by Dr. Schuman's resignation. According to the Bulletin of the Sangamon County Medical Society, the division of preventive medicine will be consolidated with the division of maternal and child health. Dr. Donaldson F. Rawlings, head of the division of maternal and child health, will be in charge of the consolidated administrative unit. Dr. Norman J. Rose will be first assistant to Dr. Rawling and will continue to handle venereal disease control and the school health program. Dr. Ruth Church, who has been working with Dr. Schuman for about a year and who was formerly a district health officer, will be on the medical staff in charge of communicable diseases.

Society News.—Dr. George M. Cummins, associate professor of medicine, Northwestern University Medical School, Chicago, discussed "Edema" before the Sangamon County Medical Society, November 4. Dr. Burtis E. Montgomery, Harrisburg, chairman, Illinois State Medical Society Advisory Committee to Illinois Public Aid Commission, addressed the business meeting.

VERMILION

Society News.—At the November 2 meeting of the Vermilion County Medical Society, Dr. Joseph Tarkington, Evanston, discussed brain injuries.

WINNEBAGO

Personal.—Three new members of the Winnebago County Medical Society are Drs. Harold P. Krueger, Bruce Marshal and Richard G. Wilson. Dr. Krueger graduated from the University of Buffalo School of Medicine; Dr. Marshall at Western Reserve University Medical School, and Dr. Wilson at the University of Iowa College of Medicine.

GENERAL

New Call for Physicians.—Colonel Paul G. Armstrong, state drector of selective service, has notified the Illinois Advisory Committee that a call has been received for 132 physicians to be inducted from Illinois on March 30, 1955. To be included in the call will be men in priorities I and II of any age and, in addition, men in priority III born after January 1, 1917.

Colonel Armstrong emphasized that physicians ordered for induction on March 30, 1955 must apply for commissions immediately, since they must be actually commissioned by that date or they will be inducted as enlisted men.

He said the National call for March is 1,275 physicians, of which the Army will receive 825, the Navy 200 and the Air Force 250.

Colonel Armstrong also pointed out that Selective Service will continue to process for physical examination and induction Priority I and II of all ages, and Priority III physicians born after January 1, 1917.

Postgraduate Conference.—The Postgraduate Education Committee of the Illinois State Medical Society, in cooperation with the faculty of the University of Illinois College of Medicine, presented a postgraduate conference at Olney, Illinois, on Thursday, January 13, 1955. The Richland County Medical Society was host.

Speakers included: Abraham F. Lash, M.D., What's New in Obstetrics and Gynecology, John T. Reynolds, M.D., What's New in Surgery; Nicholas J. Cotsonas, M.D., What's New in Internal Medicine and Heyworth N. Sanford, M.D., What's New in Pediatrics.

P. R. Day.—The Annual Public Relations Day Luncheon and Program of the Woman's Auxiliary to the Chicago Medical Society was held on November 16 in the Crystal Ballroom of the Sheraton-Blackstone Hotel. Mrs. Edward C. Helfers, Public Relations Chairman, was in charge of the program. She was assisted in arrangements by Mrs. Mathew Uznanski and the twelve member branches who acted as hostesses.

Dr. Walter C. Alvarez, the guest speaker had as his topic "How Women Make Themselves Nervous". Dr. Alvarez was introduced by Dr. Frank Fowler, President of the Chicago Medical Society. Mrs. Maurice Hoeltgen, President of the Auxiliary presided.

There were many distinguished guests from representative civic organizations. The members at large gave their full support by contacting and bringing guests from their own immediate area.

"Your Doctor Speaks" Ends with Close of Station.—On December 31, FM Station WFJL formally closed, ending five years' service. Since its inception, the **Educational Committee of the Illinois State Medical Society** has prsented a series "Your Doctor Speaks" during the entire five years. Since the last issue of the Illinois Medical Journal, the following physicians have participated:

Dale S. Raines, instructor in medicine, Northwestern University Medical School, October 28, The Electrocardiogram and How It is Used by the Physician.

Alfred L. Siegel, clinical associate in medicine, Chicago Medical School, November 4, Your Heart Attack.

Edward Bigg, assistant professor of medicine,

Northwestern University Medical School. November 11, Recent Advances in the Management of Thyroid Disease.

John F. Chase, attending physician, St. Elizabeth's Hospital, December 2, Two Common Types of Arthritis.

Raymond Grissom, member of the pediatric staff, West Suburban Hospital, December 9, Our Children's Eyes.

Paul W. Searles, Director, department of anesthesia, St. Luke's Hospital, December 16, The Role of the Anesthetist.

George M. Osborne, member of the staff of Walther Memorial Hospital, December 23, Hernia.

Mark C. Wheelock, associate professor of pathology, Northwestern University Medical School, December 30, The Pathologist's Position in Cancer.

"All About Baby" on WGN-TV.—Since the last issue of the Illinois Medical Journal, the following physicians have appeared on "All About Baby" on WGN-TV, Channel 9. A Jules Power Production, the telecast features Ruth Crowley, R.N., and physicians are invited by the **Educational Committee** of the **Illinois State Medical Society:**

Fletcher Austin, associate in otolaryngology, Northwestern University Medical School, November 24.

Morton B. Andelman, member of the pediatric staff, Sarah Morris Hospital for Children, December 1.

Alice M. Dakin, clinical associate in pediatrics, Stritch School of Medicine of Loyola University, December 8.

Irving H. Rosenthal, member of the pediatric staff, Mount Sinai Hospital, December 15.

Eleanor Hamilton, member of the pediatric staff, Holy Cross Hospital, December 22.

James P. Fitzgibbons, assistant professor of obstetrics and gynecology, University of Illinois College of Medicine, December 29.

Lectures Arranged Through the **Educational Committee** of the **Illinois State Medical Society:**

Dale S. Raines, Austin Woman's Club, January 10, on Let's Talk About Your Heart.

W. Robert Elghammer, Danville, Prairie Green PTA, Wellington, January 17, on Understanding the Adolescent.

Sol P. Ditkowsky, Sisterhood Austin Jewish Community Center, January 19, on Child Psychology.

David Slight, Woman's Auxiliary to Northwest Branch of the Chicago Medical Society, January 25, on Meaning of Mental Health.

Frederick Stenn, Gage Park Women's Club, February 22, on New Frontiers in Medicine.

Lectures Arranged Through the **Scientific Service Committee** of the **Illinois State Medical Society:**

Leon Unger, Stock Yards Branch of the Chicago Medical Society, February 18, on Some Newer Phases of Allergy.

George M. Cummins, Douglas Park Branch of the Chicago Medical Society, March 29, on Cardiovascular Aspects of Aging.

DEATHS

John Alfred Ascher, Freeport, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois in 1897, died recently, aged 79, of coronary thrombosis. He was a member of the House of Delegates of the American Medical Association in 1918; past president of the Stephenson County Medical Society; served as mayor of Freeport, and was a member of the staffs of Deaconess and St. Francis Hospitals.

Joseph L. Baer*, Chicago, who graduated at Rush Medical College in 1904, died December 8, aged 74. He was senior attending obstetrician and gynecologist and former chief of staff of Michael Reese Hospital; former president of the American Gynecological Society; and a member of the board of governors of the American College of Surgeons and the Chicago Institute of Medicine, of which he was a former president.

Robert K. Campbell*, Springfield, who graduated at St. Louis College of Physicians and Surgeons in 1908, died recently aged 74. He was a member of the American College of Chest Physicians.

Earl R. Cochran*, Rockton, who graduated at Chicago College of Physicians and Surgeons in 1908, died August 27, aged 76.

Edward A. Doepp*, retired, Blue Island, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1890, died November 28, aged 88, in St. Francis Hospital, Blue Island, which he was instrumental in founding in 1904.

Robert G. Frolick*, Quincy, who graduated at Rheinische Friedrich-Wilhelms-Universität Medizinische Fakultät, Bonn, Germany, in 1935, died August 4, aged 47, of brain tumor.

Mannie Charles Hecht*, Wilmette, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1907, died September 23, aged 70 of adenocarcinoma of the lung.

T. Gaillard Knappenberger*, Champaign, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1906, died September 14, aged 71, of heart block.

Abraham A. Low*, Evanston, who graduated at Medizinische Fakultät der Universität, Wien, Austria, in 1919, died November 17, aged 63. He was clinical associate professor of psychiatry at the University of Illinois College of Medicine.

Robert Stanton McCaughey*, Danville, who graduated at Rush Medical College in 1902, died August 9, aged 78, of pulmonary embolus, after fracture of a

* Member of the Illinois State Medical Society.

hip. He was a fellow of the American College of Physicians.

Edmund Brewer Montgomery, Quincy, who graduated at Jefferson Medical College of Philadelphia in 1878, died December 8, aged 97. He had completed 76 years of practice, was a charter member of the American College of Surgeons and a member of the "Fifty Year Club" of the Illinois State Medical Society.

Fred H. Muller*, Chicago, who graduated at Loyola University School of Medicine in 1909, died November 23, aged 68. He was a past president of the Chicago Medical Society and affiliated with the Evangelical Hospital of Chicago of which he was a past chief of staff.

Leo Oppenheimer*, Wilmette, who graduated at Julius-Maximilians Universität Medizinische Fakultät, Würzburg, Bavaria, in 1915, died November 24, aged 63. He had practiced medicine in Wilmette since 1934.

Samuel Abraham Parmuth, Chicago, who graduated at Jenner Medical College in 1913, died October 25, aged 70, of arteriosclerotic heart disease. He served on the staff of the Norwegian American Hospital.

Arthur David Pollock, Industry, who graduated at the University of Michigan Department of Medicine and Surgery, Ann Arbor, in 1898, died September 28, aged 82, of cerebral hemorrhage.

Harry Pierce Reuss*, Granite City, who graduated at Washington University School of Medicine, St. Louis, in 1910, died October 9, aged 66, of cancer. He was a fellow of the American College of Surgeons.

Isadore I. Schwager, Chicago, who graduated at Chicago College of Medicine and Surgery in 1917, died in the Mount Sinai Hospital, October 12, aged 64, of cerebral thrombosis. He was also a dentist.

Raymond G. Scott*, Geneva, who graduated at Rush Medical College in 1897, died December 8, aged 79. He was a former president of the Kane County Medical Society.

Robert Hardy Stewart*, Galva, who graduated at Chicago College of Medicine and Surgery in 1911, died in Kewanee recently, aged 73.

Joseph Edward Ursich*, LaGrange Park, who graduated at Northwestern University Medical School in 1921, died September 24, aged 59, of chronic myocarditis and coronary disease. He served on the staff of St. Anthony de Padua Hospital, in Chicago.

Shipley Wayland, Chicago, who graduated at Harvey Medical College, Chicago, in 1902, died November 11, aged 80. He had practiced medicine on Chicago's south side more than 50 years.

Gene S. Wong*, Chicago, who graduated at the Chicago Medical School in 1938, died November 13, aged 50. He was a member of the staff of Mother Cabrini Memorial Hospital.

Benjamin Franklin Zobrist*, Assumption, who graduated at St. Louis University School of Medicine in 1906, died September 4, aged 74, of heart disease. He was a past president of the Christian County Medical Society, and had served as mayor.

* Member of the Illinois State Medical Society.

‹‹‹ ›››

The research worker

Chief among trends in medical research has been the major allocation of funds for project research. In essence, this may be described as follows: an investigator outlines in greater or lesser detail (more often the former) the precise nature of the problem, the method of attack, the equipment, the personnel, and the amount of money required for its successful completion within a period of one or two years. In effect, this commits the investigator to a rigid and unswerving course from which he cannot stray to pursue promising leads and, because of the short term nature of such grants, it keeps him in a perpetual state of insecurity. *Maurice B. Strauss M.D., Project Research. BMG, June* 1954.

The silent coronary

A series of 220 cases of myocardial infarction, proved by necropsy or serial electrocardiograms, has been carefully studied. There were 10 (4.5 per cent) patients with painless infarcts. *Melvin D. Roseman, M.D. Painless Myocardial Infarction. Ann. Int. Med., July* 1954.

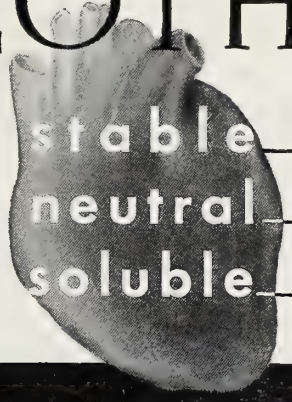
‹ ›

There has been a striking change in the tuberculosis picture over the past 25 years. A marked shift from female to male and also towards the older age groups both regarding morbidity and mortality has occurred. Tuberculosis is becoming increasingly a disease of people over 50 years of age and especially is this so in respect to males. G. C. Brink, M.D., Canadian J. Pub. Health, May, 1954.

the first
stabilized and
neutralized
"soluble derivative"
of Theophylline
(Beta Gamma Dihydroxypropyl Theophylline)

NEOTHYLLINE

(BRAND OF HYPHYLLINE)



stable — no precipitation observed when 5% solution submitted to action of gastric juices.

neutral — solutions of Neothylline in distilled water are strictly neutral.

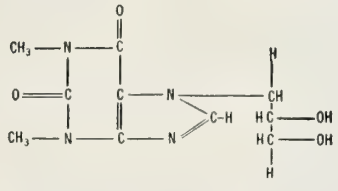
soluble — 16.5 grams in 100 c.c. water at 21° C.

in cardiovascular dilation, Neothylline is effective as a diuretic and myocardial stimulant in the management of edema secondary to congestive heart failure. Most noted is elimination of pain and normal oxygenation of the cardiac muscle.

Neothylline is also indicated in the treatment of bronchial asthma, paroxysmal cardiac dyspnea and Cheyne Stokes respiration.

Neothylline is better tolerated orally in larger doses than most theophylline derivatives (such as aminophylline) which produce gastric irritation. In contrast to the latter it can be given orally in sufficiently large doses to produce the characteristic bronchodilator and respiratory actions of theophylline compounds, as well as the well-known vasodilator (diuretic) and myocardial stimulant effect of smaller doses.

CHEMICAL COMPOSITION:
Dihydroxypropyl Theophylline



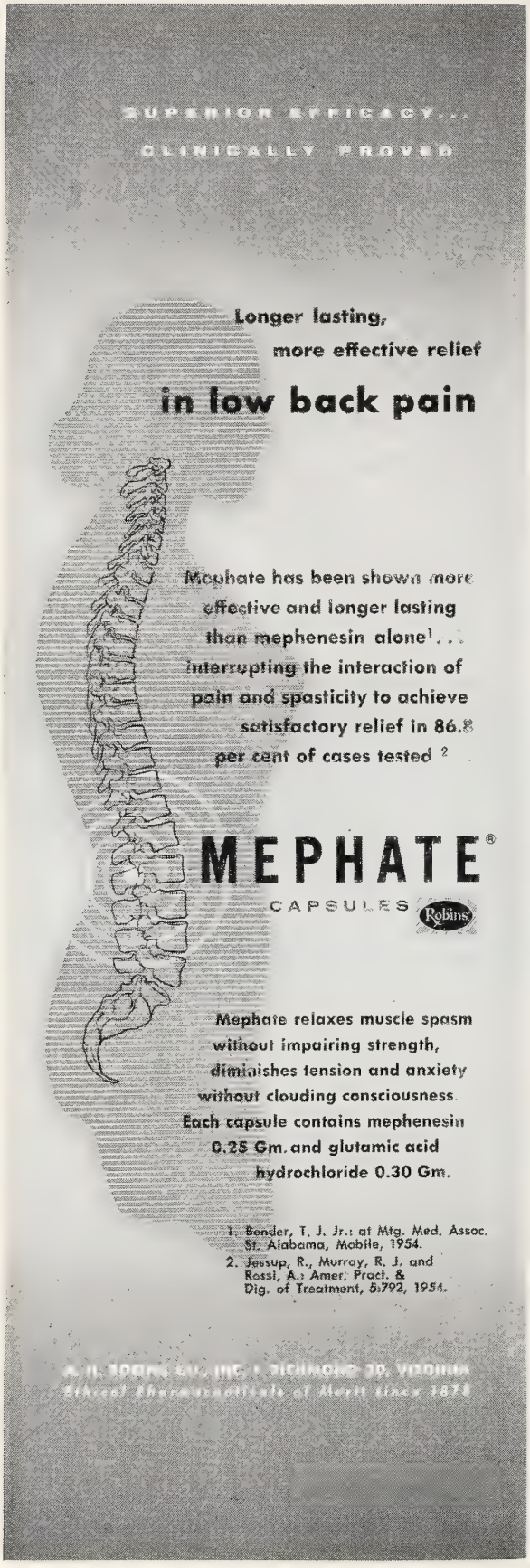
SUPPLIED
Tablets 0.1 Gm. (1½ grains)
Bottles of 100's, 500's, 1000's
Tablets 0.2 Gm. (3 grains)
Bottles of 100's, 500's, 1000's

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

Literature and clinical studies available to physicians on request.

PM

PAUL MANEY LABORATORIES, Cedar Rapids, Iowa
"Continuous Service to the Medical and Pharmaceutical Professions Since 1911"



Encouraging news

An interesting revelation of the impairment study was the finding that rheumatic fever does not carry with it an unfavorable insurance experience. In cases with a history of acute rheumatism within five years of the time of examination, the mortality rate was borderline between standard and substandard. When the attack had occurred more than five years previous to examination, mortality was normal. Deaths from diseases of the heart in this group of cases with a history of rheumatic fever were somewhat in excess of the expected death rate from this cause but it is of interest how low rather than how high the mortality rate was in this group of individuals. Within the past few years several excellent clinical studies, such as those of Jones, Bland, Wilson, and Lubschez, have likewise shown that the ultimate life expectancy of individuals with acute rheumatic fever is far better than had formerly been supposed. The study referred to, presents the first mortality experience on insured lives with chorea. The mortality data indicate that a history of an attack of chorea carries with it a moderately increased ultimate mortality rate which, in this study, actually exceeded that of acute rheumatic polyarthritis. The mortality of diseases from the heart and circulatory system was considerably in excess of that anticipated. *Harry E. Ungerleider, The Internist and Life Insurance, Ann. Int. Med., July* 1954.

‹ ›

Health insurance in Illinois

The Illinois Voluntary Health Services Plans Act of 1951 is a unique example of progressive health insurance legislation. This statute enables the formation of non-profit medical service plans under consumer sponsorship. Thirty per cent of the trustees of such groups must be licensed physicians; doctor representation is assured but lay control is permitted. Group practice is facilitated because there is no requirement that all or a majority of doctors in the area participate. The Illinois State Medical Society assisted in securing the passage of this legislation. But other medical societies have not been so forward-looking. *The American Medical Association: Power, Purpose, and Politics in Organized Medicine, The Yale Law Journal, May* 1954.



The Best Tasting Aspirin you can prescribe

The Flavor Remains Stable down to the last tablet

Bottle of 24 tablets 15¢ (2½ grs. each)

We will be pleased to send samples on request

THE BAYER COMPANY DIVISION of Sterling Drug Inc., 1450 Broadway, New York 18, N. Y.

BOOK REVIEWS

GLOBAL EPIDEMIOLOGY. A Geography of Disease and Sanitation. James S. Simmons, M.D., Tom F. Whayne, M.D., Gaylord W. Anderson, M.D., and Harold M. Horack, M.D. The J. B. Lippincott Company, Philadelphia Volume III, 1954. Price $12.00.

The first volume of this unusual book was based upon surveys made for the Medical Department of the United States Army outlining the cause and prevention of epidemic diseases and tropical diseases in general. This third volume refers to disease conditions found in the Near and Middle East, and two additional volumes are to be published later which will cover the diseases of Europe and Latin America. Data from 17 countries are reviewed in this current volume, covering geography and climate, population and socio-economic conditions, environment and sanitation, health services and medical facilities, diseases found within the respective countries, and an interesting summary for each of them.

Within the covers of this book will be found information not available in one book elsewhere, and it should be of great interest to physicians, public health workers, economists and especially to those who propose to travel in these countries.

The last section of the book entitled Health Hints for the Tropics, gives information especially for travelers, on climate, water, food, insects and insect vectors of disease, necessary immunizations and much additional and valuable information for the traveler. Information is likewise given on heat disturbances, how to dress and other essential data for those proposing to visit these countries. As frequently stated following the appearance of the two previous volumes, this book and the two which are now being prepared, will be of great value in the study of diseases and geomedical conditions throughout most of the world.

‹ ›

WINE AS FOOD AND MEDICINE. Edited by Salvatore P. Lucia, A.B., M.D., Sc.D., F.A.C.P., Professor of Medicine, University of California School of Medicine. Published by The Blakiston Company, Inc., New York, Toronto. Copyright 1954.

Wine has appeared in the amenitorium of healers since before the ancient Greeks. It is still used rather extensively on the continent. However, in the United States it has gradually fallen into disuse.

This fascinating little book deals with wine as a food and a medicine.

Dr. Lucia has explored the chemistry of wine. He has detailed its usefulness as a food and its therapeutic application in disorders of the digestive, respiratory, cardiovascular, neuromuscular systems, and in the infectious diseases.

His observations on the use of wine in the treatment of the aged and convalescent are particularly apropos. H. T.

‹ ›

INDEX OF DIFFERENTIAL DIAGNOSIS. Edited By Arthur H. Douthwaite, M.D., F.R.C.P. Seventh Edition. Published by The Williams and Wilkins Company, Baltimore. Copyright 1954.

The first edition of this text was published in 1912. Dr. Herbert French died in London in 1951. The present edition (seventh) was completed by Dr. Douthwaite, an old student of Dr.

(*Continued on page* 54)

FOR THE FIRST TIME!

A FAMOUS NAME BRAND WITH A FILTER!



OLD GOLD FILTER KINGS

One Filter Cigarette that ly Tastes like a Treat.

's the first famous name brand ve you a filter. And when you see Old Gold name on the pack, you you're getting a quality tobacco uct.

tobacco taste—the Old Gold cco men have done it again! world's most respected tobacco smen have created a wonderful filter cigarette that reflects every year tobacco heritage. Old Gold Filter Kings give you true tobacco taste in every single puff.

On sale now along with the other members of the Old Gold Family—new Old Gold Filter Kings sell at a popular filter price. Whichever kind of cigarette you prefer, just make sure it's one of the family . . . America's First Family of Cigarettes.

True filter—true flavor—The effective filter that lets real flavor through. never too tight—this easy draw filter makes every puff taste like a treat.

Doctors: Today Old Gold Filter Kings are sold in most U. S. cities, and our distribution is expanding every day. If your city does not yet have Filter Kings, simply write to P. Lorillard Company, 119 W. 40th St., New York 18, N. Y., and special arrangements will be made to make them available to you.

P. Lorillard Company

Book reviews (Continued)

French. In it he has in many instances, with the aid of contributors, almost entirely rewritten most of the articles. The general overall plan of the book, however, has remained unchanged. The index has been simplified by removing overlapping or repetitious material. Much new material has been added to keep pace with the rapid advances of medicine.

It remains, as in the past, a ready reference book for busy men in everyday practice and inquiring students. H. T.

‹ ›

ILLUSTRATED REVIEW OF FRACTURE TREATMENT. Edited by Frederick Lee Liebolt, A.B., M.D., Sc.D., LL.D. First Edition. Published by Lange Medical Publications, Los Altos, California. Copyright 1954. Price

Here is an excellent primer on fractures for use of students residences and general practitioners. The first three chapters deal with anatomy and physiology, clinical examination of fractures and principles of treatment of fractures. This approche is based upon sound general principles.

The remaining fourteen chapters deal with specific fractures by regions. These are well illustrated by line drawings which indicate not only the specific fracture, but the mechanism by which these fractures occurred. Scattered throughout the text are reproduced radiographs. Several different methods of tratment are usually clearly illustrated for each type of fracture.

A glossary and adequate index is found at the back of the book. H. T.

‹ ›

RECURRENT DISLOCATION OF THE SHOULDER: Edited by James A. Dickson, M.D. Alfred W. Humphries, M.D. And Harry W. O'Dell, M.D. Published by The Williams & Wilkins Company, Baltimore. Copyright 1953. Price $4.50.

This very scholasy monograph on recurrent dislocation of the shoulder is an attempt on the part of the authors to correlate the many divergent theories and views on its etiology and treatment.

Much confusion exists in this field among orthopedic and general surgeons because of lack

(*Continued on page* 58)

For the Aged and Senile Patient



ORAL *Metrazol*

— to help the geriatric patient with early or advanced signs of mental confusion attain a more optimistic outlook on life, to be more cooperative and alert, often with improvement in appetite and sleep pattern.

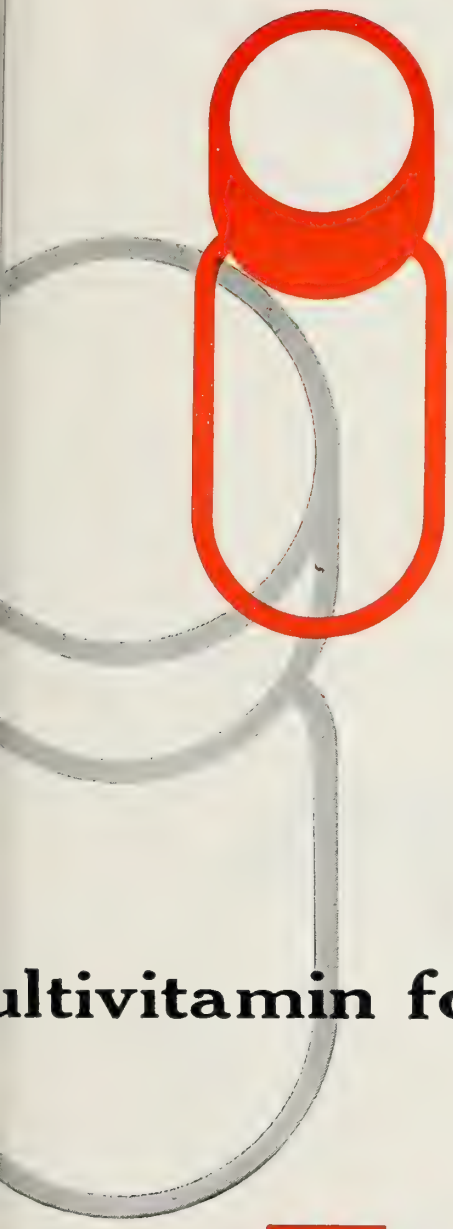
Metrazol, a centrally acting stimulant, increases respiratory and circulatory efficiency without overexcitation or hypertensive effect.

Dose: 1½ to 3 grains, 1 or 2 teaspoonfuls Liquidum, or the tablets, every three or four hours.

Metrazol tablets, 1½ grs. (100 mg.) each. Metrazol Liquidum, a wine-like flavored 15 per cent alcoholic elixir containing 100 mg. Metrazol and 1 mg. thiamine HCl per teaspoonful.

Metrazol®, brand of pentylenetetrazol, a product of E. Bilhuber, Inc.

BILHUBER-KNOLL CORP. *distributor* ORANGE NEW JERSEY



Folic Acid, a member of the vitamin B complex, is now recognized as being an essential nutritional element. It is a vital factor in the formation of not only red blood cells but all body cells and, therefore, is a contributing factor to normal growth.

During infancy and pregnancy, the need for Folic Acid is intensified. Certain macrocytic anemias sometimes observed during those periods are only one of many possible signs of folic acid deficiency, all promptly responding to this vitamin. Although it is found in a number of natural foods, Folic Acid is not usually present in abundance. As with other vitamins, it may be notably absent from certain diets.

When you prescribe a vitamin preparation, particularly for an infant, a growing child, or a mother-to-be, remember the established importance of Folic Acid and specify one of the many products that contain it!

Most leading pharmaceutical manufacturers, recognizing the essential nature of Folic Acid, include it in their multivitamin preparations. This message is presented in their behalf.

ultivitamin formulas!

Folic Acid

MEDICAL LIBRARY - UNIVERSITY OF MARYLAND

Edrisal*

S.K.F.'s antidepressant analgesic

For optimum results in dysmenorrhea



always prescribe

2

tablets

per dose

Smith, Kline & French Laboratories, Philadelphia

Each 'Edrisal' tablet contains Benzedrine* Sulfate (racemic amphetamine sulfate, S.K.F.), 2.5 mg.; acetylsalicylic acid, 2½ gr.; phenacetin, 2½ gr.

*T.M. Reg. U.S. Pat. Off.

Book reviews (Continued)

of adequate follow up on individual cases and correlation of existing pathology. The authors have made no attempt to evaluate the various methods of treatment. They are more interested in condensing this vast subject for further investigation and elaboration of more satisfactory methods of treatment.

There is an excellent bibiography at the end of the closing chapter and the line drawings and photographs are excellent.

‹ ›

ALLERGIC PRURITUS: Edited by Stephan Epstein, M.D. Panel Discussion Rudolf L. Baer, M. D., Francis W. Lynch, M.D., Stephan Epstein, M.D., Herbert Rattner, M.D., Carl Laymon, M.D., Stephen Rothman, M.D., James R. Webster, M.D. Published by Bruce Publishing Company, Saint Paul and Minneapolis. Copyright 1952. Price $2.50.

Anyone in the practise of medicine has had to deal with the annoying and exasperating problem of pruritus. We all at times have encountered cases which have by their presistence and insistance eventually proved completely frustrating.

This symposium is an official publication of the American College of Allergists. The seven contributors were selected because of their large personal experience in this field.

The subject is thoroughly explored from the physiology, pharmacology, psychosomatic and infectious aspects of etiology through all phases of treatment including ACTH and Cortisone.

The prospective reader must bear in mind that this is not a textbook on the subject of allergic pruritus, but rather a series of essays by men of vast clinical experience.

‹ ›

BOOKS RECEIVED

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

SANDOZ ATLAS OF HAEMATOLOGY. Sandoz Ltd., Basle, Switzerland, 1952. Address requests to Sandoz Blood Atlas, 68 Charlton Street, N.Y. 14, N.Y. $7.00.

STANDARD VALUES IN NUTRITION AND METABOLISM. The second fascicle of a Handbook of Biological

(*Continued on page* 60)

fast-acting salicylate formula
HIGH in analgesic power
LOW in risk to the patient

Recent studies[1,2] suggest that the time-tried salicylates exert a *hormonal* action similar to that of ACTH, stimulating release of cortisone.

Whenever rapid and sustained salicylate action is desired, **ELPAGEN** gives your patient the benefits of a *potentiated* salicylate combination in *uncoated* tablet form—without the gastric irritation of unmodified salicylates and without the potential dangers (or expense) of ACTH or cortisone itself.

ELPAGEN / PATCH

Each orange-colored, uncoated tablet provides:

Sodium salicylate	5 gr.	(325 mg.)	*POTENTIATED SALICYLATE BLOOD LEVELS*
Sodium para-aminobenzoate	3 gr.	(195 mg.)	
Salicylamide	½ gr.	(32.5 mg.)	

plus

Ascorbic acid 30 mg. (as sodium ascorbate)		*SAFEGUARD AGAINST VITAMIN C DEPLETION AND CAPILLARY HEMORRHAGE*
Dihydroxy aluminum aminoacetate	½ gr.	(32.5 mg.) BUFFERING ACTION *OVERCOMES GASTRIC INTOLERANCE*[3]

SUPPLIED in bottles of 100 and 500 tablets.

1. Van Cauwenberge, H.: Lancet 261:374, 1951; Van Cauwenberge, H., and Heusghem, C.: Proc. Soc. Exper. Biol. & Med. 80:51, 1952. 2. Pelloja, M.: Lancet 1:233, 1952. 3. Paul, W. D., et al.: J. Am. Pharm. A., Scient. Ed. 39:21, 1950.

THE E. L. PATCH COMPANY

STONEHAM • MASSACHUSETTS

Books received (Continued)

Data. Edited by Errett C. Albritton, A. B., M. D., Fry Professor of Physiology, The George Washington University. Prepared under the Director of the Committee on the Handbook of Biological Data, American Institute of Biological Sciences, The National Research Council. 380 pages. W. B. Saunders Company, Philadelphia, London, $6.50.

Pediatric Diagnosis. Morris Green, M. D., Assistant Professor of Pediatrics, Yale University School of Medicine, and Julius B. Richmond, M. D. Professor and Chairman of the Department of Pediatrics, State University of New York College of Medicine at Syracuse. 436 pages. W. B. Saunders Company, Philadelphia, London, $10.00.

Review of Medical Microbiology. By Ernest Jawetz, Ph. D., M. D., Professor of Bacteriology and Lecturer in Medicine and Pediatrics, University of California School of Medicine, San Francisco, and Joseph L. Melnick, Ph. D., Professor of Epidemiology, Yale University School of Medicine, New Haven, and Edward A. Adelberg, Ph. D., Assistant Professor of Bacteriology, University of California, Berkeley. Lange Medical Publications, P. O. Box 1215, Los Altos, California. $4.50.

The City of hope. By Samuel H. Golter. G. P. Putnam's Sons, 210 Madison Avenue, New York, New York. $3.50.

Sports Injuries — Prevention and Actives Treatment. By Christopher Woodard, Honorary Consultant to British Olympic Teams, 1948 and 1952. Max Parrish Publisher, London. Distributed in the U. S. by Track & Field News, P. O. Box 296-V, Los Altos, California. $3.00.

Ciba Foundation Symposium on Hypertention — Humoral and Neurogenic Factors. Editors for the Ciba Foundation — G. E. W. Wolstenholme, O. B. E., M. A., M. B., B. Ch., and Margaret P. Cameron, M. A., A. B. L. S., Assisted by Joan Etherington. 73 illustrations. Little, Brown and Company, Boston. $6.75.

Handbook of Medical Treatment. Fourth Edition. Lange Medical Publications. $3.00.

The Adolescent Child — A Realistic Approach to Treatment and Training. Proceedings of the 1954 Spring Conference of the Child Research Clinic of The Woods Schools, held in New Orleans, Louisiana, April 9 and 10. Sponsored by The Woods Schools — a non-profit residential school for Exceptional Children, Langhorne, Pennsylvania. No charge.

The Role of the Pituitary in Cancer. The Clinical value of pituitary lipid treatment. By Henry K. Wachtel, M. D., The William-Frederick Press, New York, 1954. $2.00.

This drug has proved able
to control the disease
in two-thirds of patients
with ulcerative colitis,
who had previously failed to
respond to standard colitis
therapy currently in use*.



* See MORRISON: Rev. of Gastroent., Oct. 1953.

Azulfidine
BRAND OF SALICYLAZOSULFAPYRIDINE

PHARMACIA LABORATORIES, INC.
270 Park Avenue, New York 17, N. Y.



Dual Action in Dermatoses

rational therapy
in dermatoses
where infection exists
or threatens

Exclusive

Terra-Cortril*

topical ointment

TERRA-CORTRIL Topical Ointment is the new, easy-to-write name for CORTRIL Topical Ointment with TERRAMYCIN Hydrochloride.

TERRAMYCIN®

The exclusive, proved broad-spectrum antibiotic with world-wide clinical acceptance — discovered and developed by Pfizer.

CORTRIL®

The predominant anti-inflammatory glucocorticoid, made more readily available through Pfizer fermentation production methods.

supplied: in ½-oz. tubes, 3% TERRAMYCIN (oxytetracycline hydrochloride) and 1% CORTRIL (hydrocortisone) in an easily applied ointment base.

also available:

CORTRIL Topical Ointment
CORTRIL Tablets
CORTRIL Acetate Ophthalmic Ointment
CORTRIL Acetate Aqueous Suspension for intra-articular injection
TERRA-CORTRIL Ophthalmic Suspension

Pfizer

PFIZER LABORATORIES
Division, Chas. Pfizer & Co., Inc.
Brooklyn 6, New York

**brand of oxytetracycline and hydrocortisone*

Define and spell it out

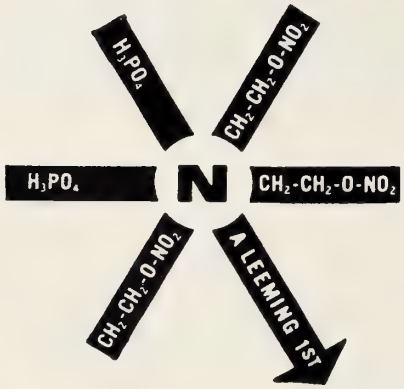
There is urgent need today for organized medicine to summon all of its divergent elements and to define and spell out a reasonable relationship, especially between general practitioners and specialists. To illustrate: The American College of Surgeons has declared it a breach of ethics for a surgeon to use a referring general practitioner as an assistant. Granting that on occasions such assistance may be but a subterfuge for a split fee and, granting that the general practitioner has no vested interest in his patient he nevertheless, often by being the family doctor, holds a trusteeship toward his patient's health, which would be poorly served were he forced off the case when surgery is involved. Most of us who are members and strong supporters of the College believe this to be wrong, believe it will discourage requests for consultation and reference of cases, and will serve to isolate general practitioners into a resentful and dissident group. The principle which I wish to emphasize is that questions as basic as that of ethics and that of all-important relationships is a matter to be settled by organized medicine as a whole and not by a special group, no matter how sincere the motives or how great the qualifications to advise. *O. J. Campbell, M.D., Problems and Obligations of Organized Medicine. Minnesota Med., June* 1954.

‹ ›

The works

If the patient is having enough trouble with his back to spend his time and money for a medical opinion, don't let him go without getting an x-ray film. This is important for every patient with a backache. I don't know of any luxury that is more expensive and less productive than poor films. The films must be of good quality. Every now and then films are mailed to us that must have been taken on a cloudy day in London, because you can just see the haze of a battleship or a ship in the harbor; aside from that you can't tell what it is. To know if there is any arthritic lipping or any narrowing of a disk space or the possibility of a metastasis from carcinoma, you must have good diagnostic films. *Carlo Scuderi, M.D., Backache, Postgrad. Med., April* 1954.

Angina pectoris prevention



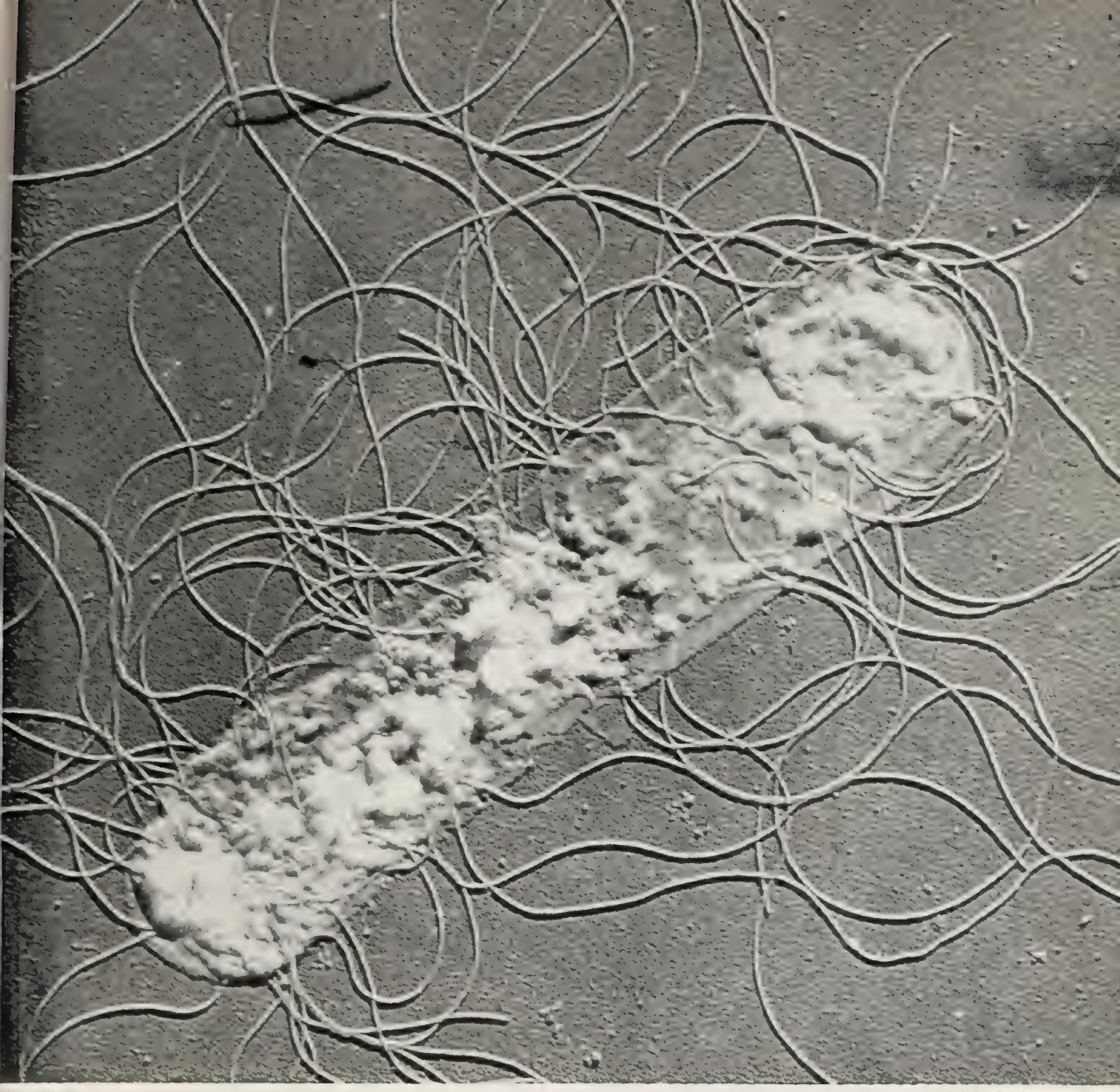
Most efficient of the new long-acting nitrates, METAMINE prevents angina attacks or greatly reduces their number and severity. Tolerance and methemoglobinemia have not been observed with METAMINE, nor have the common nitrate side effects such as headache or gastric irritation. DOSE: 1 or 2 tablets after each meal and at bedtime.

Thos. Leeming & Co. Inc.
155 East 44th St., New York 17, N. Y.

unique amino nitrate

Metamine

triethanolamine trinitrate biphosphate, Leeming, tablets 2 mg. Bottles of 50 and 500



ELECTRON PHOTOMICROGRAPH COURTESY R.C.A. LABORATORIES

Proteus vulgaris 29,000 X

Proteus vulgaris is a Gram-negative organism commonly involved in

urinary tract infections • septicemia

peritonitis following low perforation of the gut.

It is another of the more than 30 organisms susceptible to

PANMYCIN*

TETRACYCLINE HYDROCHLORIDE

100 mg. and 250 mg. capsules

*TRADEMARK, REG. U. S. PAT. OFF.

Upjohn

Miami Heart Institute

A non-profit Cardio-vascular Center
Endorsed by Florida Heart Association

Accommodations for
ambulant patients and guests

Recreation—Research—Rehabilitation

Staff open to Dade County
Medical Association

4701 N. Meridian Avenue,
Miami Beach, Fla.

On Beautiful Surprise Lake.

THUMBSUCKING

since infancy caused this malocclusion.



THUM TRADE MARK

THUM broke the habit and teeth returned to normal position.

ACCEPTED FOR ADVERTISING IN PUBLICATIONS OF THE AMERICAN MEDICAL ASSOCIATION

Get Thum at your druggist or surgical dealer.
Prescribed by physicians for over 20 years.

Mercy Hospital Institute of Radiation Therapy

The Henry Schmitz Medical Group

For Appointment
VIctory 2-4700, Ext. 170 or RAndolph 6-4444

Herbert E. Schmitz, M.D., *Director*
Peter A. Nelson, M.D., *General Oncology*
Henry L. Schmitz, M.D., *Internal Medicine*
Janet Towne, M.D., *Gynecology*
Robert L. Schmitz, M.D., *General Surgery*
John F. Sheehan, M.D., *Pathologist*
Charles J. Smith, M.D., *Gynecology*
Charles S. Gilbert, M.D., *Internal Medicine*
William F. Cernock, M.D., *Internal Medicine*
Fred W. Eims, *Physicist*
Miss Hilda Waterson, R.N.
Helen Hansen, *Social Service*

COMPLETE TUMOR THERAPY
Including
SUPERFICIAL X-RAY THERAPY
DEEP X-RAY THERAPY up to 1,000 K.V.
RADIUM THERAPY

Daily Consultation at Institute
Tumor Clinic—Mercy Free Dispensary—Tuesday at 9 a. m.
Tumor Conference — J. B. Murphy Auditorium — Friday at 1 p. m.

The cervix and uterus

Some of us were taught in medical school to put one finger in the vagina and one finger on our nose. If the cervix felt like the nose it was normal; if it was harder, it was the site of cancer; and if it was softer, then the woman was pregnant. This one-finger examination, however, is not entirely satisfactory. One finger in the rectum and one in the vagina, with the other hand on the abdomen, offers a far better and much more accurate aid to diagnosis. Then we get information not only about the cervix but also about the uterus, adnexa, and rectum, and if carcinoma is present we can estimate the stage of the lesion as well. The stage of the disease must always be determined on the initial visit and the patient kept in the indicated category if we are to compare results later, though from a diagnostic point of view, the surgical findings are the most accurate. *Joseph Hyde Pratt, M.D., Carcinoma of the Cervix. Postgrad. Med., June* 1954.

‹ ›

Some will never learn anything because they understand everything too soon. *Blount.*

Do You Know ? ? ?

THE SPECIAL DISABILITY PLAN
AVAILABLE TO MEMBERS OF
THE ILLINOIS STATE MEDICAL SOCIETY

Provides Benefits up to . .

$5000. ACCIDENTAL DEATH AND DISMEMBERMENT

$100. PER WEEK FOR TOTAL LOSS OF TIME as the result of either Sickness or Accident.
$15. DAILY HOSPITALIZATION for up to 90 days as the result of either Sickness or Accident.

Plus . . .

Optional 5 Year Sickness Coverage
No reduction in benefits because of other insurance
Full benefits to age 70 at same cost
(All Benefits Subject to Provisions of the Policy)

FOR ALL THE FACTS - - -
Write or Telephone

PARKER, ALESHIRE & COMPANY
175 W. JACKSON BOULEVARD
Chicago 4, Ill. WAbash 2-1011

Greater Comfort
for the Hypertensive Patient

Simpler Patient Management
for the Physician

Combination Therapy

IN SINGLE TABLET FORM

- No complicated dosage instructions different for each drug . . .
- Dosage governed only by response to potent antihypertensive component . . .
- Potentiating action of Rauwiloid® produces full efficacy of potent drug from lower dosage . . .
- Fewer and less burdensome side actions because of smaller doses needed.

Rauwiloid® + Veriloid®

Rauwiloid 1 mg. and Veriloid 3 mg.

IN A SINGLE TABLET

Initial dosage, 1 tablet t.i.d., p.c. In bottles of 100, an average month's supply.

Rauwiloid® + Hexamethonium

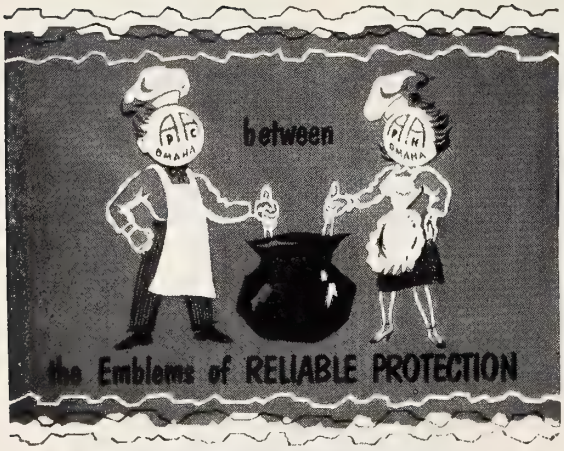
Rauwiloid 1 mg. and Hexamethonium Chloride Dihydrate 250 mg.

IN A SINGLE TABLET

Initial dosage, ½ tablet q.i.d., before meals and on retiring. In bottles of 100 slow-dissolving scored tablets. For cautions to be observed with hexamethonium, a booklet is available on request.

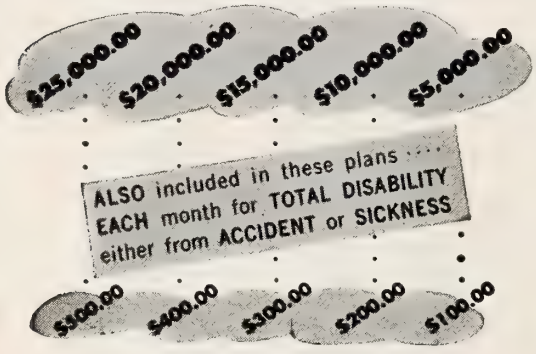
Riker LABORATORIES, INC., LOS ANGELES 48, CALIF.

Something NEW
is Cooking



MORE INSURANCE NOW AVAILABLE

think! HOW THESE AMOUNTS WOULD HELP IN PAYING ESTATE TAXES IN CASE YOU ARE ACCIDENTALLY KILLED . . .



SPECIFIC BENEFITS ALSO FOR LOSS OF SIGHT, LIMB OR LIMBS FROM ACCIDENTAL INJURY

$4,000,000 Assets
$20,000,000 Claims Paid
52 Years Old

Physicians Casualty & Health Ass'ns.
Omaha 2, Nebraska

Over specialization

How far specialization has developed and how absurd it may appear is well illustrated by an incident that occurred recently in a well known teaching institution (this came to my attention not through the usual medical channels but through a discussion group of Blue Shield executive directors). In a discussion of the method of division of the total fee when more than one surgeon was involved in a given operation, the following incident was given as an example of the problem: a general surgeon in a New England hospital had made a diagnosis of acute appendicitis but when the abdomen was opened it was found that the patient had an ovarian cyst with a twisted pedicle rather than appendicitis. This condition fell within the field of gynecology. According to the rules of the hospital, the general surgeon was not allowed to do gynecologic operations. It was necessary to call in a gynecologist to remove the ovarian cyst. The surgeon was then permitted to remove the appendix and close the abdomen. This concept of specialization is difficult to justify but it is evidence of the degree of departmentalization that may occur under the conditions of specialization as it is now known. *Leland S. McKittrick, M.D., Specialty Practice. New England J. Med., July* 8, 1954.

‹ ›

Recovery from lung cancer

I think an important point to drive home is that the patient with lung cancer who is salvable is a patient who usually has a symptomless cancer and one without physical findings, who will have a demonstrable lesion on chest x-ray, and whose diagnosis can best be proved by exploratory thoracotomy. I have never quite understood why we as a group have a different fundamental concept about the cancer we have to look at in an x-ray and the one we can palpate with our fingers. I find that almost routinely, my senior students are willing to explore a breast for a palpable nodule but are unwilling to have an exploratory thoracotomy for a symptomless tumor they look at in an x-ray. It takes quite an effort to teach them that this is the proper procedure. *Norman Wilson, M.D., The Harmful Effects of Tobacco. New York Med., May* 5, 1954.

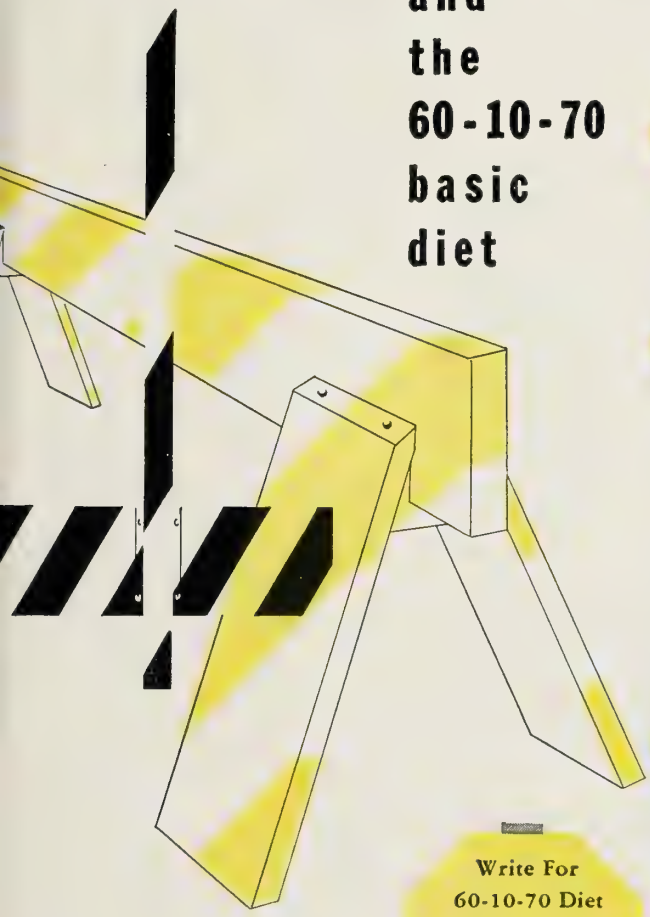


overcoming weight control obstacles

Obedrin®

and the 60-10-70 basic diet

Patients can lose weight and maintain a restricted diet, in comfort, without undesirable side effects . . .



EXCESSIVE DESIRE FOR FOOD

Obedrin offers the full anorexigenic value of Methamphetamine to curb the desire for food, while counteracting mood depression. Patient co-operation is made easier.

NERVOUS TENSION

To avoid excitation and insomnia, Pentobarbital is the ideal daytime sedative. It counteracts over-stimulation by Methamphetamine, but does not diminish the anorexigenic action.

VITAMIN DEFICIENCIES

Obedrin tablets contain adequate amounts of vitamins B_1 and B_2 to supplement the 60-10-70 Basic Diet, but not enough to stimulate the appetite.

EXCESSIVE TISSUE FLUIDS

Large doses of Ascorbic Acid aid in the mobilization of fluids, so often an obstacle in obesity.

BULK NOT NECESSARY

The 60-10-70 Basic Diet provides enough roughage, so artificial bulk is unnecessary. The hazards of impaction caused by "bulk" producers is obviated.

Write For 60-10-70 Diet Pads, Weight Charts And Professional Sample Of Obedrin

S. E. MASSENGILL CO.

Bristol, Tennessee

Each tablet contains:

Semoxydrine HCl (Methamphetamine HCl)	5 mg.
Pentobarbital	20 mg.
Ascorbic Acid	100 mg.
Thiamine HCl	0.5 mg.
Riboflavin	1 mg.
Niacin	5 mg.

for CHILDREN with EDUCATIONAL and ADJUSTMENT PROBLEMS

. . . a private resident school for children of average or superior intelligence whose psychological difficulties impair their learning abilities and school progress.

. . . enrolling children from seven to fourteen years of age. Coeducational. Small classes. Remedial reading. Brochure on request.

. . . provides a program of education with psychotherapy.

. . . out-patient psychiatric evaluation and consultation for children.

ANN ARBOR SCHOOL

A. H. Kambly M.D., Director

411 First National Building Ann Arbor, Mich.



Cooper Creme

no finer name in contraceptives



active Ingredients:
Trioxymethylene .04%
Sodium Oleate 0.67%

FREE

Whittaker Laboratories, Inc. Dept. 6
Peekskill, New York

Please send: Full Size $1.50 Combination Package Free—Cooper Creme/Dosimeter.

Name _____ M.D.

Address _____

City _____ Zone _____ State _____

Whittaker Laboratories, Inc., Peekskill, New York

Exposure to x-ray

The etiology of leukemia remains a mystery. The only well known cause is that due to irradiation with x-rays. In radiologists, the incidence of leukemia is approximately eight times that in a comparable group of physicians in other specialties. Frequent and prolonged x-ray exposure with laxity in protection almost certainly favors leukemia. A single high dosage exposure of x-rays and gamma radiation may also produce leukemia, as shown by the studies following the atom bomb explosions in Hiroshima and Nagasaki. Several causes for leukemia have been suggested. Among those which deserve the most serious consideration are chemicals such as benzene or carcinogenic hydrocarbons. The possibility that over the years, humans are toxically exposed to these chemicals or their derivatives is suggested as an explanation for the increased incidence of leukemia. *Editorial, Control of Leukemia. J. M. Soc., New Jersey, July* 1954.

‹ ›

"Tem" in leukemia

Triethylene melamine (TEM) has been most effective in the treatment of chronic leukemias and leucosarcomas. It is valuable in many cases of Hodgkin's disease, chronic lymphocytic leukemia, chronic granulocytic leukemia, and lymphosarcoma. It must be given with great caution and it should never be given in doses greater than 2.5 mg. A test dose is worthwhile because an occasional patient shows severe reactions, both generalized and hematologic. In the first course the dose should be no larger than 2.5 mg., given three times in the first week and twice in the second. The drug is always administered an hour before breakfast. *Editorial, Control of Leukemia. J. M. Soc. New Jersey, July,* 1954.

‹ ›

The importance of the tuberculin test in the program for the elimination of tuberculosis cannot be overestimated. The percentage of positive tuberculin reactors is an indirect measure of the amount of undetected open tuberculosis in the community. The presence of a positive tuberculin test pinpoints the individuals which comprise the group in which new active cases will develop. The discovery of a recent conversion from a negative to a positive tuberculin reaction means that there is a known or unknown active case among the converter's associates. David T. Smith, M.D., J. School Health, Sept., 1954.

Income* for the members of the Illinois Medical Profession from the first day* of sickness or injury...

NOW! Not for only 26 weeks

— Not for only 52 weeks

but even for your entire lifetime

House Confinement not required at any time

Accidental loss of hands, feet or eyesight pays monthly benefits — not just a lump sum

TAX FREE DOLLARS — Disability insurance income is not taxable. For example, $3600 disability insurance income is equivalent to about $5000 regular income

EXTRA BENEFITS — Double monthly benefits while you are hospitalized payable for as long as three months

Cash benefits for accidental death

Double income benefits if disabled in specified travel accident named in the policy

OTHER IMPORTANT FEATURES — Waiver of Premium Provision • Limited Commercial Air Line Passenger Coverage • No Automatic Termination Age During Policy Period • A Special Renewal Agreement

Covers most accidents from date of policy and most sickness originating more than 30 days after date of policy, excepting those incurred while in military service of any country at war, or resulting from war, any act of war, suicide, attempted suicide, insanity, mental disease, certain foreign travel, any pre-existing condition or any hazard of aviation other than commercial air line passenger travel

UNITED INSURANCE COMPANY

MP—30

UNITED INSURANCE COMPANY, Life Disability Income Dept.

Bankers Building, 105 W. Adams St., Chicago, Illinois

I would like more information about your lifetime disability income protection

I understand I will not be obligated

Name ..... Age .....

Address .....
or attach letterhead

***Income payable from first day of medical attention and as long as continuous total disability, total loss of time and medical attendance continue**

Mail coupon today while you are still healthy

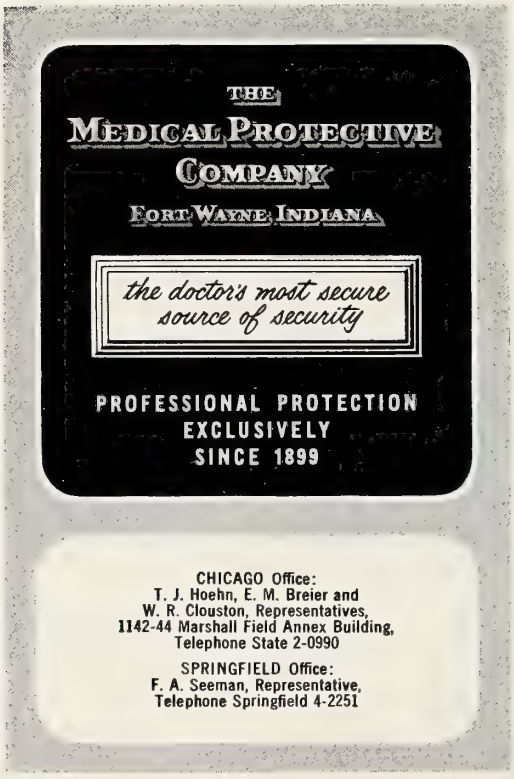
North Shore Health Resort

on the shores of Lake Michigan
WINNETKA, ILLINOIS
NERVOUS and MENTAL DISORDERS
ALCOHOLISM and DRUG ADDICTION
Modern Methods of Treatment
MODERATE RATES

Established 1901 — *Fully Approved by the*
Licensed by State of Illinois — *American College of Surgeons*

SAMUEL LIEBMAN, M.S., M.D.
Medical Director

225 Sheridan Road — Winnetka 6-0211



Fluoride and bone

Exposure to fluoride in drinking water was studied for evidence of detrimental effects on skeletal calcification and bone development in children. Three groups of children aged 7 through 14, living in Lubbock and Amarillo, Tex., and Cumberland, Md., were selected on the basis of continuous exposure to their communal drinking waters, which contained fluoride in the amounts of 3.5 to 4.5 p.p.m. F, 3.3 to 6.2 p.p.m. F, and 0.1 p.p.m. F, respectively. Radiographs were taken of the right hand and wrist of 2,050 children. From these x-rays, the skeletal age was assessed and a quantitative index of ossification was determined. No evidence, available by the radiographs, was obtained which would indicate that there was any adverse effect on the carpal bones or on their growth and development as a consequence of the continuous use of drinking water containing approximately 3.5 to 6.2 p.p.m. F. These results confirm the safety of maintaining the fluoride level of public water supplies at about 1.00 p.p.m. F, by controlled fluoridation, for the reduction of tooth

FAIRVIEW
Sanitarium

DEVOTED TO THE ACTIVE TREATMENT OF

MENTAL and NERVOUS DISORDERS

Specializing in Psycho-Therapy, and Physiological therapies including:

- **Electro-Shock**
- **Electro-Narcosis**
- **Insulin Shock**
- **Carbon Dioxide Therapy**

Out Patient Shock Therapy Available

ALCOHOLISM Treated by Comprehensive Medical-Psychiatric Methods.

2828 S. PRAIRIE AVENUE, CHICAGO 16 J. DENNIS FREUND, M. D., Medical Director

Phone Victory 2-1650 — **Registered by the American Medical Assn.**

The NORBURY SANATORIUM

JACKSONVILLE, ILLINOIS — INCORPORATED and LICENSED

For the Treatment of Nervous and Mental Disorders

FRANK GARM NORBURY, M.D., Medical Director
HENRY A. DOLLEAR, M.D., Superintendent
FRANK B. NORBURY, M.D., Associate Physician

Address Communications — THE NORBURY SANATORIUM, Jacksonville, Illinois

decay. *H. Berton McCauley, D.D.S. and F. J. McClure, Ph.D., Effect of Fluoride in Drinking Water. Pub. Health Rep., July* 1954.

‹ ›

Retrolental fibroplasia

The incidence of retrolental fibroplasia seems to be increasing out of proportion to the increased number of premature infants who have survived. Owing to this disease, between 12 and 15 per cent of all prematures weighing less than 4 pounds at birth become blind. It is the principal cause of blindness in the preschool child. In this country, there are approximately 700 blind babies a year as a result of this disease; when all the proposed premature nurseries are established, it is expected that this number will double or even triple. Because of this increasing incidence, speculation has arisen as to whether or not the condition is produced by one of the various therapeutic agents employed to combat the hazards of prematurity. *Katherin Brokaw, M.D., and Irma Waldo, M.D., Retrolental Fibroplasia. J. Am. W. Women's A., June* 1954.

DOCTOR! you will approve the
3C's
Comfort, Cleanliness,
Convenience



at Bee Dozier's 3 Sanitariums for
Aged, Chronic, Senile, Convalescent Patients.

Hickory Hill,
Maple Hill, *Palatine*

Charming, healthful rural locations conveniently situated, 24 hour care by trained nurses and orderlies, tempting food and supervised diets all contribute to your patient's well-being or recovery. 18 years of experience.

ONE rate covers EVERYTHING. There are NO extras.

Bee Dozier invites your inspection. Write Box 288, Lake Zurich, Ill., or Phone 4661

in whooping cough

ELIXIR BROMAURATE

IS A UNIQUE REMEDY OF UNIQUE MERIT

Cuts short the period of illness and relieves the distressing spasmodic cough. Also valuable in Bronchitis and Bronchial Asthma.

In four-ounce original bottles. A teaspoonful every 3 to 4 hours.

Prescribed by Thousands of Doctors

GOLD PHARMACAL CO. — NEW YORK CITY

The incidence is changing

The past generation has witnessed radical changes in the relative prevalence of the various types of heart disease. Adequate data are not available from mortality statistics but the point is well illustrated by clinical statistics collected in New England in 1925 and in 1950 by Dr. Paul D. White. The figures show that the proportion of cases of heart disease due to rheumatic fever has been cut in half during this quarter century, from approximately two-fifths to one-fifth of the total. At the same time, the proportion from coronary heart disease has more than doubled, from approximately one-fifth of the total to more than two-fifths. Relatively, the incidence of hypertensive heart disease has declined slightly, while the proportion of cases of syphilitic heart disease dropped to less than one-fourth of what it was 25 years ago. *The Pattern of Heart Disease Mortality. Statistical Bull., Metropolitan Life Insurance Co., May* 1954.

Yellow urine

A deep yellow color of the urine is found during vitamin B complex therapy and after ingestion of large quantities of fruit (peaches). This urine characteristically has a slight suggestion of fluorescence. *Robert Lich, Jr., M.D., Urine. J. Kentucky M.A., July* 1954.

‹ · ›

The outlook in tuberculosis

Twenty years ago one of every five children admitted to the tuberculosis ward of Bellevue Hospital died of the disease, usually within a year. Most of these children were first diagnosed in the hospital because a tuberculin test was part of the examination on admission. Of those who were admitted with the diagnosis of tuberculosis, the great majority had originally been found by contact examinations or by tuberculin tests. The death rate in tuberculous children was unchanged until streptomycin became available late in 1946. *Edith M. Lincoln, M.D., NTA Bull., March* 1954.

Lederle

GRAVIDOX*

Pyridoxine-Thiamine *Lederle*

For preventing and treating Hyperemesis Gravidarum

Pyridoxine (B_6) and Thiamine (B_1) have proved more effective in combination than either alone in the prevention and treatment of the nausea and vomiting of pregnancy. GRAVIDOX, in both tablet and parenteral form, combines these vitamins, providing you with a nutritional approach to the problem. GRAVIDOX may also be useful for the prevention and relief of the nausea and vomiting associated with radiation sickness.

Each GRAVIDOX tablet contains: Thiamine HCl—20 mg., Pyridoxine HCl—20 mg. Each cc. of GRAVIDOX parenteral solution contains: Thiamine HCl—50 mg., Pyridoxine HCl—50 mg.

Average dose: 5 to 12 tablets daily, in divided doses, at times when vomiting is less likely to occur; or 1 cc. parenteral solution 2 or 3 times weekly.

LEDERLE LABORATORIES DIVISION AMERICAN Cyanamid COMPANY Pearl River, New York

*REG. U. S. PAT. OFF.

Your Advertisers



Our advertisers serve the Medical Profession and support your Journal. All advertisers are approved by your Journal Committee. It will help you to mention your Journal and your Society when writing them.

CIGARETTES

Brown & Williamson 44
P. Lorillard 53

CLASSIFIED

Classified Advertisements 84

FINANCIAL AND INSURANCE

The Medical Protective Co., Fort Wayne, Ind. 78
Parker, Aleshire & Co., 175 W. Jackson Blvd. Chicago 4, Illinois 72
Physicians Casualty Co., First National Bank Bldg. Omaha 2, Nebraska 74
United Insurance Co., 105 W. Adams St., Chicago 4, Illinois 77

FOODS

American Bakers Ass'n., Chicago, Ill. 28
American Meat Institute, Chicago 5, Illinois 64
General Foods Corporation (Sanka Coffee) 48
Knox Gelatine Co., Inc., New York 41
Mead Johnson & Co., Evansville, Indiana. Inside Back Cover

LABORATORIES

Mercy Hospital, Institute of Radiation Therapy, Chicago, Illinois 72

PHARMACEUTICALS

Abbott Laboratories, North Chicago, Illinois 6, 7, 34, 62, 63
American Cyanamid Co., Fine Chemicals Division, New York 20, N. Y. 35, 56, 57
Ames Company, Elkhart, Indiana 20
Ayerst Laboratories, New York 7, N. Y. 32
Bilhuber-Knoll Corporation, Orange, N. J. 54
Bayers Aspirin, New York 18, N. Y. 49
Ciba Pharmaceutical Products, Summit, N. J. 4, 82
Davies, Rose & Co., Boston 18, Mass. 61
Paul B. Elder Co., Bryan, Ohio 47
Endo Products, Inc., Richmond Hill 18, N. Y. 12, 67
Geigy Company, New York 13, N. Y. 30
Gold Pharmacal Co., P.O. Box 181, New York 77, N. Y. 79
Harrower Laboratory, Inc., Jersey City 6, N. J. 40
Hoffman-LaRoche, Inc., Nutley 10, N. J. 9, 51, 52
Lederle Laboratories, 10 Rockefeller Plaza, New York 20, N. Y. 10, 22, 23, 38, 68, 69, 80
Thomas Leeming & Co., Inc., 155 E. 44th St., New York 17 ..... 3, 66
Eli Lilly & Co., Indianapolis 6, Indiana 42
Paul Maney Laboratories, Cedar Rapids, Iowa 45
S. E. Massengill Co., Bristol, Tennessee 17, 75
Wm. S. Merrill Co., Cincinnati, Ohio 24
Num Specialty Co., Pittsburgh, Pa. 72
Parke, Davis & Co., Detroit 32, Michigan 31
E. L. Patch Company, Stoneham, Mass. 59
Pfizer Laboratories, Div. of Pfizer & Co., Brooklyn, N. Y. 18, 19, 65
Pharmacia Laboratories, New York 17, N. Y. 60
Riker Laboratories, Inc., 8480 Beverly Blvd., Los Angeles, Cal. 16, 29, 73
A. H. Robins Co., Inc., Richmond 20, Virginia 25, 46
J. B. Roerig & Co., Chicago 11, Illinois 11
Schering Corporation, Bloomfield, N. J. 33
Julius Schmid, Inc., 423 W. 55th St., New York 19, N. Y. 36
G. D. Searle & Co., P.O. Box 511, Chicago, Ill. ..... Inside Front Cover
Smith, Kline & French Laboratories, Philadelphia, Pa. 14, 15, 43, 58, 70
E. R. Squibb & Sons, 747 Fifth Ave., New York, N. Y. . 26
U. S. Vitamin Corporation, New York 17, N. Y. 37
Upjohn Co., Kalamazoo, Michigan 13, 21, 39, 55, 71, 81
Whittaker Laboratories, Peekskill, N. Y. 76
Winthrop-Stearns, Inc., 1450 Broadway, New York 18, N. Y. 27

SANATORIA AND SANITARIA

Bee Dozier Sanitarium, Box 288, Lake Zurich, Ill. 79
Bellevue Place, Batavia, Illinois 84
Fairview Sanitarium, 2828 S. Prairie Ave., Chicago, Ill. .. 78
Keeley Institute, Dwight, Illinois 84
Lincolnview Hospital & Sanitarium, Springfield, Ill. 84
Miami Heart Institute, Miami Beach, Florida 72
Milwaukee Sanitarium Foundation, Inc., Wauwatosa, Wisconsin ..... Back Cover
Norbury Sanitarium, Jacksonville, Ill. 79
North Shore Health Resort, 225 Sheridan Road, Winnetka, Ill. 78

SCHOOLS

Ann Arbor School, 411 First National Bldg., Ann Arbor, Mich. 76

BELLEVUE PLACE

For

NERVOUS and MENTAL DISEASES

★

Edward Ross, M.D., Medical Director
BATAVIA ILLINOIS
PHONE BATAVIA 1520



LINCOLNVIEW

Hospital and Sanitarium
Springfield, Illinois
8th & Capitol

Albert P. Ludin, M. D., Medical Director

MENTAL-ALCOHOLIC-ADDICTED

Rapid Intensive Treatment

Registered A.M.A. Licensed State of Illinois

Phone 2-3303

Classified Ads

RATES FOR CLASSIFIED ADVERTISEMENTS—For 30 words or less: 1 insertion, $3.00; 3 insertions, $8.00; 6 insertions, $14.00; 12 insertions, $24.00; from 30 to 50 words: 1 insertion, $4.00; 3 insertions, $10.50; 6 insertions, $20.00; 12 insertions, $30.00. Extra words: 1 insertion 10c each; 3 insertions, 25c each; 6 insertions, 40c each; 12 insertion 50c each. A fee of 25c is charged for those advertisers who have answers sent care of the Journal. Cash in advance must accompany copy.

VACANCIES IN MENTAL HOSPITALS: RESIDENTS IN PSYCHIATRY. Five year program consisting of three years in residency training and two years of employment in an Ill. mental hospital, qualifying for the examination by the American Board of Psychiatry and Neurology in an approved mental hospital facility, eligible for licensure as a physician in Ill. Salary: $5,000 per year. CONTACT: Percival Bailey, M.D., Director, State Psychopathic Institute, 912 So., Wood St., Chicago, Illinois.

VACANCIES IN MENTAL HOSPITALS:—PHYSICIANS: (3 levels) Physician I, $380 to $550 mo., less maint; Physician II, $500-$600 mo, less maintenance; Physician III, $550 to $720 mo., less maint. Psychiatrist I, $500 to $660 mo., less maint.; Psychiatrist II, $600-$785 mo., less maint.; Psychiatrist III, $700 to $860 mo., less maint.; Phychiatrist IV. $660-$980 mo., less maint. CONTACT: Paul Hletko, M.D., Chief Medical Officer, Department of Public Welfare, 160 No. LaSalle St., Chicago, Ill.

WANTED: Retired woman missionary doctor licensed in Illinois would like part time work. Box 220, Ill. Med. Jl., 185 N. Wabash, Chicago 2.

PARK FOREST MEDICAL CENTER OFFICES AVAILABLE. Rental includes All services-phone, receptionist, Pharmacy in connection. Call American Community Bldrs. INterocean 8-9000 or write No. 2 Plaza, Park Forest, Ill.

WANTED: Gen'l Surgeon, Board eligible, desires location northern half of state, for private or group practice. Married. Age 32. Modern hosp. required. Available after Army discharge 31 July 55. Box 219, Ill. Med. Jl. 185 N. Wabash, Chicago 2. 3/55

Pruritus Ani

The results of this study reveal Efocaine® to be highly useful preparation for the management of pruritus ani. With careful adherence to minimal dosage as well as to technic, the injection of the drug is simple and may be readily done as an office procedure. The patient undergoes relatively little discomfort during the injection of the product and usually within a short time, he experiences dramatic relief from itching, which persists over a period of days. *John R. O'Brien, M.D., Efocaine in Pruritus Ani. J. M. Soc. New Jersey, July,* 1954.

New problems

Technological advances that have helped in conquering many sources of infection have in turn created new environmental problems: occupational and household hazards; ionizing radiations; stresses and strains of noise, speed, light, and crowded living; pollution of streams, lakes, and coastal waters by industrial wastes and chemical contamination; substances and methods used in processing food; maintenance of increasingly complicated food handling equipment; substandard housing; sanitation in areas suffering from disaster; air pollution; and a host of others. *Panel on Public Health Manpower to Meet Changing Health Needs. Pub. Health Rep., July* 1954.

‹ ›

Moving to the suburbs

Our suburbs are the fastest growing areas in the country. During the 1940-1950 decade, the population in communities bordering our larger cities increased by 7,200,000, or nearly two-fifths. This is more than three times the rate of growth within these cities and more than double that for the United States as a whole. Moreover, there are indications that population increase in suburban areas has been continuing unabated since 1950 and in fact may be proceeding at a record rate. *Suburban Population Growth. Statistical Bull., Metropolitan Life Insurance Co., July* 1954.

THE KEELEY INSTITUTE
DWIGHT, ILLINOIS

Treating alcoholism and other problems of addiction.

REGISTERED BY THE AMERICAN MEDICAL ASSOCIATION—
MEMBER AMERICAN HOSPITAL ASSOCIATION.

Table of Contents

FEBRUARY, 1955
Vol. 107, No. 2

YOUR ANNUAL MEETING—CHICAGO—MAY 17, 18, 19, 20

Editor
Harold M. Camp
Monmouth, Illinois

Associate Editor
Theodore Van Dellen
Chicago, Illinois

Business Manager and Managing Editor
Mr. L. E. Malley
185 N. Wabash Avenue
Chicago 1, Illinois

Business Office
185 N. Wabash Avenue
Chicago 1, Illinois

Editorial Office
Medical Arts Building
Monmouth, Illinois

Send original articles and membership correspondence to Harold M. Camp, Monmouth, Ill.

Send changes in the mailing list to Managing Editor, 185 N. Wabash Ave., Chicago 1, Ill.

Subscription price of this JOURNAL to persons not members of the Illinois State Medical Society is $4.00 per year, in advance, postage prepaid, for the United States, Cuba, Puerto Rico, Philippine Islands, Hawaiian Islands and Mexico. $5.00 per year for all foreign countries included in the postal union. Canada, $4.50. Single current copies 50 cents. By mail, 60 cents.

ORIGINAL ARTICLES

Exophthalmos Associated with Thyroid Disease. G. LeRoy Porter, M.D., and James S. Walker, M.D., Urbana 57
The Diagnostic Value of Pain In Nonpenetrating Abdominal Injuries. Chester C. Guy, M.D., Chicago 62
Reichstein's Substance S Acetate—A New Therapeutic Agent. John Peters, M.D., Oak Park 64
A Review of 202 Cases of Bacterial Endocarditis, 1948-1952. Melvin L. Afremow, M.D., Chicago 67
Emotional Aspects of Allergic Mainfestations, Irving L. Turow, M.D., Peoria 73
Looking Forward in Public Health. Roland R. Cross, M.D., Springfield 77
Glucagon. S. O. Waife, M.D., (Seminar) 81
Retroperitoneal Cystadenoma of the Ovary. (Cook County Hospital Case Records.) Frank J. Jirka, Jr., M.D., and Thomas W. Samuels, M. D., Chicago 84
Combined Treatment with N-allylnormorphine and L-arterenol Controlled with Methadone Poisoning. (Case Report) Peter Pulos, M.D., Arthur Bernstein, M.D., Lawrence Perlman, M.D., Chicago 87
A Psoriatic Rheumatoid Arthritic; Successful Result with Massive Cortisone Therapy. (Case Report) A. Lieberman, M.D., Ph.D. 89

EDITORIALS

Foreign medical schools 92
Andy Hall's 90th birthday 92
Committee On Industrial Health resolution 93
David John Davis 1875-1954 94
History of Medical Practice in Illinois 95
Book reviews 58A

MEDICAL ECONOMICS

Is Our Workmen's Compensation System Satisfactory? Frederick W. Slobe, M.D., Chicago 96

CORRESPONDENCE

Annual Clinical Conference 99
Invitation to physicians' wives 101
Clinics for crippled children listed for March 101
1955 college essay award contest 102
Illinois tuberculosis association notes 102

NEWS OF THE STATE 103

Re-entered as Second-Class Matter November 12, 1952 at the Post Office, Mendota, Illinois, under the Act of March 8, 1879. Acceptance for mailing at special rate postage provided for in section 1102, Act of October 8, 1917, authorized July 15, 1918. Printed monthly by The Wayside Press, Mendota, Illinois. Office of Publication, 1501 W. Washington Road, Mendota, Illinois. POSTMASTER — Return undeliverable copies under form 3579 to 1501 W. Washington Road, Mendota, Illinois.



TO INITIATE THERAPY

ACHROMYCIN INTRAMUSCULAR

ACHROMY

LEDERLE LABORATORIES DIVISION *AMERICAN Cyanamid COMPANY* Pearl River, New York

The
ILLINOIS
Medical Journal



Official Journal of The Illinois State Medical Society

FEBRUARY 1955
VOL. 107 NO. 2

EXOPHTHALMOS Associated With THYROID DISEASE

G. LeRoy Porter, M.D., and James S. Walker, M.D., Urbana

OCULAR involvement associated with thyroid dysfunction is extremely variable. Treatment may require the services of specialists in several fields of medicine. From the ophthalmologic standpoint hyperthyroidism may conveniently be classified as follows: (1) no ocular involvement, (2) lid retraction alone or combined with simple protrusion of the eyes, not sufficient to interfere with either the function or integrity of ocular structures (this type is usually termed thyrotoxic exophthalmos), (3) protrusion of the eyes associated with some or all of the following: edema of the eyelids, chemosis of the conjunctiva, engorgement of orbital and ocular vessels, paresis or paralysis of extraocular muscles, failing vision, edema or atrophy of the optic nerve, impaired nutrition of the cornea, exposure keratopathy and panophthalmitis (this type may be referred to as thyrotropic, pituitary, or malignant exophthalmos). The unscientific nature of this classification is obvious but it serves a useful purpose for the ophthalmologist.

The separation of exophthalmos into the above two types is still controversial but the rationale of treatment is based upon its acceptance. Thyrotoxic exophthalmos results from stimulation of the cervical sympathetic ganglion by excessive thyroid secretion. Reduction of this secretion to a normal level by any means will usually result in recovery. Because the signs and symptoms are mild and respond readily to control of the thyroid disease, ophthalmologists are seldom called upon in the management of these cases.

Thyrotropic, pituitary, or malignant exophthalmos may be the result of excessive production of thyroid stimulating hormone, and possibly an "ophthalmotropic" hormone, by the pituitary gland. The present discussion is primarily concerned with the treatment of this type of exophthalmos which is difficult to control. Obviously the treatment should be directed toward reducing the activity of the pituitary gland. Medical therapy for this purpose should be supervised by the internist. Usually the patient will be found to have subnormal thyroid activity. Administration of thyroid extract and Lugol's solution is indicated to inhibit the formation of

From the Department of Ophthalmology and Otolaryngology, Carle Hospital Clinic and Carle Memorial Hospital, Urbana, Illinois.

Presented before the Section on Eye, Ear, Nose and Throat, 114th annual meeting, Illinois State Medical Society, Chicago, May 18, 1954.

pituitary hormones. If this treatment is contraindicated or ineffective x-ray therapy of the pituitary, as advocated by Beirewaltes[1], should be instituted. Previously x-ray therapy to the orbits has been used but is no longer advocated. Surgical destruction or electrocoagulation of the pituitary for this purpose has been suggested, but not tried, by Braley[2]. Effects of x-ray therapy usually begin about three months after administration. During this period continued progression of the exophthalmos may occur threatening the integrity of the globe and endangering vision. Should this occur cortisone or ACTH therapy is indicated. Kinsell[3] found improvement within 48 hours in all of 9 patients so treated. These drugs presumably act either by an inhibiting effect on thyrotropin or because of a "lytic effect" upon mononuclear cells. The effectiveness of this method of treatment is controversial. Aterman[4] found in experimental work with animals that exophthalmos produced by injections of thyrotropin was increased by the simultaneous administration of cortisone or ACTH.

Should these procedures be ineffective surgical treatment is indicated. A two point blepharorrhaphy should be done in conjunction with decompression of the orbit, which may be accomplished by removal of any of its four walls. Removal of the lateral or superior wall of the orbit permits the orbital contents to displace surrounding soft tissues whereas removal of the medial or inferior wall allows the orbital contents to prolapse into an actual, rather than a potential, space. Removal of the superior wall by intracranial approach was devised by Naffziger[5] in 1931. It is a major surgical procedure and fatalities have resulted. Although adequate recession of the protruding orbital contents is usually obtained a troublesome postoperative pulsation may occur. Removal of the lateral wall, as advocated by Swift[6], is a less hazardous major surgical procedure. Guyton[7] has reported excellent results using a modification of this method. Kistner[8] has reported success following removal of the ethmoid sinus and floor of the frontal. Successful decompression by removal of the orbital floor has been described by Hirsch[9]. Despite obvious advantages of decompression into the antrum this technique has been used infrequently. In the cases to be reported two were treated successfully by this method.

Case 1

Thyrotropic Exophthalmos Developing After Thyroidectomy Arrested by X-Ray Therapy to the Pituitary

Mrs. C. T., No. 34497, age 61, was first seen in the Carle Hospital Clinic on August 6, 1949 with a diagnosis of hyperthyroidism. The examiner noted "prominent eyes" but the patient was not seen in the eye department and exophthalmometer measurements were not made. Subtotal thyroidectomy was performed November 7, 1949. The immediate postoperative course was uneventful .In May 1950 she complained of poor vision not corrected by a change of glasses. There was no recurrence of hyperthyroid symptoms and the basal metabolic rate was within normal limits. In June 1950 the exophthalmos was increased. Lugol's solution was prescribed at this time. In September 1950 the patient was first seen in the eye department. Corrected visual acuity was right 6/9, left 6/6. Lid retraction was present and exophthalmometer (Hertel) readings were right 23½, left 20½. Ocular tension was right 33, left 26 (Schiotz). There was no lid edema, chemosis of the conjunctive or restriction of ocular movements. Glaucomatous type excavation was present in the right optic disc. 2% pilocarpine was prescribed for each eye. In October 1950 the tension was controlled but a definite restriction of upward rotation of the eyes and severe photophobia were noted. In January 1951 there was moderate edema of lids and slight chemosis of the conjunctiva. Exophthalmometer readings were right 24, left 22. At this time irradiation of the pituitary was instituted. Five months later there was marked subjective improvement. Edema of the lids and conjunctiva had completely subsided. Rotations were much improved and exophthalmometer measurements were right 22, left 19. In December 1951 there were no ocular complaints and the glaucoma was well controlled by miotics. Rotations were normal. Some lid lag persisted. When last seen in January 1954 her general health was good and she was having no ocular difficulties. Examination was essentially unchanged from December 1951 although it was possible to demonstrate slight paresis of the right superior oblique, right internal rectus and right external rectus muscles.

Case 2

Thyrotropic Exophthalmos Associated with Hyperthyroidism. Progression Following Thyroidectomy Arrested by X-ray Therapy to the Pituitary

Mrs. G. D., No. 76365, age 50, was first examined at the Carle Hospital Clinic in April 1949. A diagnosis of exophthalmic goiter was made. Symptoms had existed about four months. The patient believed that her eyes had become more prominent during the preceding two months.

Eye examination revealed normal visual acuity, exophthalmometer measurements of 18 bilaterally, mild conjunctival edema, no lid lag and normal ocular fundi.

Considerable difficulty was encountered preparing the patient for surgery. Lugol's solution was inadequate and administration of antithyroid drugs and digitalis were required. In June she complained of epiphora, burning of the eyes and blurring of vision when reading. Convergence insufficiency and a slight paresis of the left inferior oblique were present. Moderate chemosis of the bulbar conjunctiva was noted. Exophthalmometer measurements were right 19, left 20. A subtotal thyroidectomy was done in July. The eyes were again examined in September. Exophthalmometer readings were right 20, left 21. Otherwise there was little change. By November exophthalmos had increased to 22 in each eye. Visual acuity was reduced to 6/12, chemosis of the bulbar conjunctiva was increasing and both corneas had multiple diffuse punctate staining areas. She was receiving Lugol's solution and her thyroid status was considered satisfactory. X-ray therapy was administered to the pituitary at this time. Six weeks later the visual acuity was reduced to right 6/18, left 6/15. Moderate lid edema was present and impairment of upward rotation was noted. Three months following completion of x-ray therapy the vision returned to 6/12 in each eye, the corneas were normal and both conjunctival and lid edema had subsided. She was seen again in December 1952, two years following x-ray therapy, at which time she stated that following the last observation her vision had returned to normal and her eyes had become comfortable, although they remained prominent. Her general condition was satisfactory. Visual acuity was 6/6 in each eye. Exophthalmometer measurement was 23 bilaterally and no thyrotropic signs were present. Ocular rotations were unimpaired and there was no palpebral or conjunctival edema. In March 1954 exophthalmometer readings were right 19, left 20. The remainder of the eye examination was essentially normal.

Case 3

Thyrotropic Exophthalmos Without Hyperthyroidism Treated by X-ray Therapy

Mrs. R. R., No. 112818, age 45, was first seen May 5, 1953. She had noted intermittent diplopia and an increasing prominence of the eyes for the preceding six months. An ophthalmologist prescribed glasses without benefit. A second ophthalmologist advised a general physical examination which disclosed no evidence of hyperthyroidism. There were no complaints other than those referable to the eyes. Eye examination revealed normal visual acuity with glasses. Exophthalmometer readings were right 20, left 20. Moderate lid edema was present. Cover test disclosed 7 prism diopters of exophoria and 8 prism diopters of right hyperphoria. A study of the ocular rotations revealed paresis of the left superior rectus and the right medial rectus. The remainder of the examination was not significant. There were no clinical manifestations of hyperthyroidism. The basal metabolic rate was —4. Roentgen studies of the skull and orbits were normal as were all other x-ray and laboratory examinations. X-ray therapy to the pituitary was administered from May 18 to May 23. In July she reported her eyes felt more comfortable. Exophthalmometer measurements were 19 in each eye but the lid edema and paresis of extraocular muscles were little changed. By December hyperphoria was reduced to 1 prism diopter and exophoria to 4 prism diopters. Exophthalmometer readings were unchanged. The patient felt completely relieved of eye symptoms. In March 1954 no change was observed and she remained asymptomatic.

Case 4

Progressive Exophthalmos Following Thyroidectomy not Responding to X-ray Therapy. Bilateral Transantral Orbital Decompression with Good Results

Mr. H. P., No. 94685, age 58, was first seen in the Carle Hospital Clinic April 23, 1951, with typical symptoms of hyperthyroidism existing the preceding six months. Medical preparation for surgery was satisfactory and subtotal thyroidectomy was performed on May 9, 1951. He was first seen in the eye department on the day prior to surgery. He stated that his eyes had become more prominent during the previous three months. For one month there had been some blurring of vision and intermittent horizontal diplopia. The eyes appeared prominent although exophthalmometer measurements were only 17 in each eye. Stellwag's sign was present. Visual acuity was 20/40 in each eye. Esophoria measured 11 prism diopters for distance and 6 prism diopters at 33 cm. 1 prism diopter of left hyperphoria was observed. No definite paresis of the lateral rectus muscles was noted on ocular rotations or by the red glass test. The hyperphoria was comitant. No conjunctival or lid edema was present nor was there engorgement of the ocular veins. The fundi appeared normal. His next eye examination was six months following surgery. He stated that his eyes had become progressively worse during this period. Double vision was constant and not relieved by glasses with base out prisms. Orbital discomfort, ocular irritation and congestion associated with increasing prominence of the eyes had developed. His basal metabolic rate was normal. Visual acuity was 20/50 in each eye and exophthalmometer readings were right 19, left 18. There was marked engorgement of the ocular veins, moderate edema of the lids and chemosis of the conjunctiva and mild paresis of both lateral rectus muscles. X-ray therapy to the pituitary was administered at this time. One month later all the previously noted findings were more marked. Lagophthalmos and mild exposure keratopathy were present. Ocular rotations in all directions were impaired with complete loss of function of the lateral recti. The right eye was more severely involved and loss of the globe appeared imminent. Accordingly, on December 14, 1951, a two point blepharorrhaphy and a transantral decompression were done under local anesthesia. One week following surgery very little lid edema remained, chemosis of the conjunctiva had subsided, there was no corneal staining and the right eye appeared to have receded although measurement was impossible. Gross impairment of ocular rotations remained. The left eye became progessively worse neces-



Figure 1. Case 4 prior to orbital decompression.



Figure 2. Case 4 three months following surgery.

sitating a similar operation on January 14, 1952. Prompt improvement followed. Three months following surgery the belpharorrhaphies were separated. Lid edema, ocular congestion and chemosis of conjunctiva had subsided satisfactorily and the corneas were normal. Exophthalmometer measurements were right 16, left 17. Improvement in ocular rotations occurred but both lateral rectus muscles remained impaired. 2 prism diopters of left hyperphoria and 7 prism diopters of esophoria were present for distance. Visual acuity was reduced to right 20/40 and left 20/60. A mild pallor of both optic discs was observed. The basal metabolic rate was —22 and he was receiving thyroid extract daily. At the last examination in December 1953 his condition was essentially unchanged except for mild nuclear sclerosis and subcapsular lens changes in each eye.

Case 5

Thyrotoxic Exophthalmos Changing to Thyrotropic Exophthalmos Following Thyroidectomy Requiring Bilateral Orbital Decompression

Mr. R. G., No. 111732, age 50, was first seen in the Carle Hospital Clinic on March 12, 1953. Severe hyperthyroidism of 3 months duration was present. A marked thyrotoxic type of exophthalmos was observed. Subtotal thyroidectomy was performed April 3, 1953. He was examined first in the eye department 12 days following thyroid surgery. Marked lid retraction was noted and the eyes appeared prominent although exophthalmometer readings were 17 in each eye. No thyrotropic signs were present. In May exophthalmometer readings were 20 in each eye but again no thyrotropic signs were noted. In July the exophthalmos had increased to 22 in each eye and early thyrotropic signs were observed. X-ray therapy was administered to the pituitary. By August 14 marked lid edema, chemosis of the conjunctiva, ocular congestion and limitation of rotations had developed. Loss of the left eye appeared imminent. Blepharorrhaphy and orbital decompression were performed on the left side at this time and on the rigtht side one month later. Response to surgery was excellent. Exophthalmos receded to 17 in each eye and all lid edema and chemosis of the conjunctiva subsided. The corneas appeared normal permitting release of the blepharorrhaphies two months following surgery. Mild impairment of both upward and downward rotations persisted.

COMMENT

Despite the theoretical physiologic basis for control of thyrotropic exophthalmos by administration of thyroid hormone, we have observed little benefit from its use. We believe that pituitary irradiation is more likely to be effective if administered early in the course of the disease. The treatment used in our cases was 1000 r delivered to the pituitary region in divided doses over a period of 10 to 14 days. While we have had no experience with cortisone or ACTH therapy we feel it may be indicated for temporary control in fulminating cases. We wish to emphasize the importance of orbital decompression, combined with a two point blepharorrhaphy, relatively early in the course of the disease. If operation is deferred until irreversible vascular and fibrodegenerative changes have occurred in the orbit results will be much less favorable.

The surgical phase in the treatment of malignant exophthalmos has been neglected in favor of medical and x-ray therapy. Unfortunately the exophthalmos may continue to increase before a satisfactory effect from the latter two therapeutic procedures is obtained. Surgical interference has been undertaken with reluctance in the past. Substitution of lateral decompression for the transcranial method has been a definite step forward but this operation is still a major one. Early operation under these circumstances



Figure 3. Case 5 one month after left orbital decompression and prior to right decompression.



Figure 4. Case 5 four months following surgery.

is too often deferred. The advantages of transantral decompression are obvious. No preparation is needed, no special instruments are required and no assistant is necessary. Thus emergency decompression of the orbit may be done easily, quickly, and successfully. Danger of infection is minimal, convalescence short and no cosmetic deformity results.

In two cases bilateral orbital decompression was required to save the eyes. Removal of the orbital floor seemed the logical procedure. The technique of this operation is familiar to all otolaryngologists. Under local anesthesia the usual Caldwell-Luc sinus operation is performed and in addition the floor of the orbit is removed. The bone is quite thin, easily fractured with a small chisel and completely removed without difficulty. Two anteroposterior incisions are made in the bulging periosteum dividing the orbital floor into thirds. The central third is left intact but a coronal incision is made in the center of each lateral third. This allows a free decompression of orbital contents into the antrum. In spite of these relaxing incisions orbital fat prolapses slowly and is cohesive in contrast to its behavior in the normal orbit.

SUMMARY

The progressive steps in a program for controlling exophthalmos associated with thyroid dysfunction have been presented. Failure to respond to one step indicates utilization of the next succeeding method. Three cases responding to x-ray therapy to the pituitary gland and two cases requiring surgical decompression of the orbit have been described.

REFERENCES

1. Beierwaltes, W. H.: Irradiation of the Pituitary in Malignant Exophthalmos. J. Clin. Endocrinol., 11:512-530, 1951.
2. Braley, A. E.. Malignant Exophthalmos. Am. J. Ophth., 36:1286-1290, 1953.
3. Kinsell, L. W., Partidge, J. W., and Foreman, N.: The Use of ACTH and Cortisone in the Treatment and in the Differential Diagnosis of Malignant Exophthalmos: A. Preliminary report. Ann. Int. Med., 38:913-917, 1953.
4. Aterman, K.: Cortisone and Experimental Exophthalmos. Lancet, London. 1:23, p. 1143-1144. June 1952.
5. Naffziger, H. C.: Progressive Exophthalmos Following Thydoidectomy. Its Pathology and Treatment. Ann. Surg., 94:582, 1931.
6. Swift, G. W.: Malignant Exophthalmos and Operative Approach. West. J. Surg., 43:119-126, 1935.
7. Guyton, J. S.: Decompression of the Orbit. Surg. 19:790-809, 1946.
8. Kistner, F. B.: Decompression for exophthalmos. J.A.M.A., 122:37-38.1939.
9. Hirsch, O.: Surgical Decompression of Malignant Exophthalmos, Arch. Otolaryng., 51:325-334, 1950.

The Diagnostic Value Of Pain In Nonpenetrating Abdominal Injuries

Chester C. Guy, M.D., Chicago

SYMPTOMS of nonpenerating abdominal injuries depend on damage to the thoracic or abdominal walls including rib fractures and lacerations of muscles or blood vessels; damage to solid viscera including liver, spleen, pancreas, and kidneys; and damage to hollow viscera of the gastrointestinal tract.

With injuries of the thoracic and abdominal walls, pain usually is severe. Hemorrhage in the abdomen of itself seldom leads to severe pain; for example, ruptured ectopic pregnancy may be almost painless. Peritonitis is always painful although the degree depends on several factors including age and physique of the patient, whether or not shock is present, the character of the insult, and the length of time since the accident occurred. Injuries to the solid viscera cause hemorrhage; pain is variable. Hollow visceral injuries produce mainly peritonitis and marked pain.

INDIVIDUAL INJURIES

Chest Wall —In chest wall injuries, particularly if associated with fractured rib pain usually is severe. Splinting of the muscles of the chest wall and abdomen occurs, together with grunting respirations and a variable degree of shock. Early findings may be misleading so far as intra-abdominal trauma goes. Rupture of the liver always must be considered in fractures of the right lower ribs and rupture of the spleeen in fractures of the left lower ribs.

Abdominal Wall — Rupture of the rectus muscles from direct violence, together with tears of the deep epigastric vessels in the lower abdomen, are not rare and symptoms often suggest intra-abdominal injuries or hemo-peritoneum. Rupture of the epigastric vessels from mild abdominal trauma or physical exertion are most frequent in women with lax abdominal walls. The clinical picture may be mistaken for appendicitis, twisted ovarian cyst, intestinal obstruction, or some other intra-abdominal lesion.

SOLID ORGANS

Liver — Massive tears of the liver produce severe hemorrhage, profound shock, and early death. They are seen more often by the coroner's physician than by the surgeon. Surgery seldom is helpful. Minor tears of the organ are frequent and usually heal spontaneously. Later, pain may develop from bile leakage and biliary peritonitis, with slow pulse and jaundice. The occurrence of these symptoms may indicate surgical drainage. Liver injuries are not primarily painful and should be treated conservatively, at least soon after the injury.

Pancreas — Blunt trauma to the epigastrium may cause hemorrhages in and around the pancreas; pain usually is not severe. Activation of leaking pancreatic juices may result in pancreatitis which becomes increasingly painful and a mass forms due to fluid accumulation in the lesser peritoneal cavity. A blow sufficient to injure the pancreas may induce other intra-abdominal pathology but the treatment of pancreatic trauma, per se, as well as pancreatitis, should be conservative.

Kidneys — In kidney injuries, hemorrhage generally is associated with more or less local inflammation from urinary extravasation. Pain is great and the picture may simulate injuries to other intra-abdominal organs. Ruptured kidney from nonpenetrating violence seldom is accompanied by rupture of the intestinal tract, although injury of the left kidney often is combined with rupture of the spleen. Rupture of the kidney is associated with grossly bloody urine in 75 per cent of the cases and microscopically bloody urine in 95 per cent. If abdominal pain

Abstract of discussion in a Symposium on Abdominal Pain, given at the Illinois State Medical Society annual meeting, Chicago, May 19, 1954.

s thought to be due to a ruptured kidney, the ntravenous pyelogram may be diagnostic. Early reatment is conservative.

Spleen — Rupture of the spleen is readily overooked when associated with painful fractures of the lower left ribs. As a rule, there is no arly massive intra-abdominal hemorrhage but there is a gradual development of a perisplenic hematoma. This lesion may give local pain, pain on deep respiration, and pain in the left shoulder. X-ray findings may be helpful in diagnosis. Seven to 14 days after the original injury, secondary hemorrhages are not rare. Mortality from ruptured spleen, with primary or secondary hemorrhage, is about 90 per cent unless splenectomy is successfully performed. Persistent pain in the splenic area following blunt violence calls for careful observation of the patient for at least two weeks.

GASTRO-INTESTINAL TRACT

The stomach seldom ruptures although rupture of the duodenum, especially of the retroperitoneal portions, is not rare. These accidents produce severe pain due to escape of the highly irritating contents of the upper small bowel. When exploring an injured upper abdomen, the surgeon should look particularly for edema, with discoloration of the peritoneum over the retroperitoneal portion of the duodenum. This may be the only clew to a retroperitoneal rupture of this organ. Such lesions are always fatal unless closed surgically soon after the injury. Injuries of the small intestine are frequent and hemorrhage may dominate the picture, particularly since lacerations of the mesentery often are present. If the small bowel is empty at the time of injury there may be comparatively little leakage of its contents and late development of peritonitis. Rupture of the colon is most common in the descending bowel and sigmoid. The contents here may be comparatively solid and the peritoneal insult less severe immediately following injury, than in rupture of the right colon. The latter are less common but the liquid contents of the right colon are highly irritating and early and severe peritonitis is to be expected.

In any case of nonpenetrating injury of the abdomen, associated with pain or evidence of hemorrhage, x-ray studies by flat plate are indicated. These films may be particularly helpful in rupture of the spleen and of less value in injuries to the kidney, liver, and pancreas. Rupture of the stomach or colon may result in the finding of free air below the diaphragm. Free air is almost never found with rupture of the small intestine.

It is suggested that pain in abdominal injuries must be interpreted in view of what organs may have been damaged. When there is reasonable suspicion of rupture of the spleen or the gastrointestinal tract, the wisest course of treatment is early exploration, a policy of "look and see" rather than "wait and see". When rupture of the liver, pancreas, or kidney is suspected the early therapeutic program should be conservative. Better anesthesia, available blood banks, and antibiotics have had important influences on lowering mortality from abdominal injuries. But the fact remains that the correct treatment depends largely on close observation and accurate interpretation of symptoms and findings. The location, type, and degree of pain may be the most important single diagnostic finding in nonpenetrating abdominal injuries.

Reichstein's Substance S Acetate — A New Therapeutic Agent

John Peters, M.D., F.A.C.P., Oak Park

17-Hydroxy-11-Desoxycorticosterone 21-Acetate, known as Reichstein's Substance S Acetate, differs from Cortisone Acetate in that it does not possess an oxygen molecule at C11. This material was made available to one of us several years ago for experimental purposes. Details of a few cases were reported in the Illinois Medical Journal in October 1951. In the past two years, we have treated a variety of unrelated diseases with this substance. From our observations and those of others that have experimented with it, we concluded that Reichstein's Substance S Acetate has therapeutic value.

A detailed report of all of the findings in a large series of our cases would require a great deal of space and we therefore eliminate many details and present only our clinical observation of its therapeutic value.

History:

Mr. H—age 29 in June of 1952 began to have severe pains and swelling in his feet and was not able to follow his occupation. He has also had migraine headaches for many years. His condition was diagnosed as gout and he was treated with various remedies including Colchicine to which his response was only temporary. In September of 1952 he became acutely ill, and was hospitalized.

Course and Treatment: The significant laboratory findings: blood uric acid of 6.8. He was given 12.5 mgs. (½ cc) of Reichstein's Substance S Acetate intramuscularly twice daily. On the third day, he reported less pain and the swelling subsided. On the fifth day, he was free from pain and was able to stand on his feet. His uric acid at that time was 2.9. He remained in the hospital for ten days. Threatment continued with daily injections of 12.5 mgs. for 30 days and every other day for two weeks. At the present time—approximately one year since his treatment began—this patient has been free of all symptoms. He walks from 6 to 8 miles per day in a railroad yard and follows no diet.

Mr. R. J. S.—age 55 has been a victim of gout for the past fifteen years. He obtained partial relief from the use of Colchicine. He followed a strict diet and abstained from alcohol. He was treated with Cortisone and ACTH, to which he did not respond. Instead he developed severe retention.

Course and Treatment: In May 1951, he began treatment with 12.5 mgs. of Reichstein's Substance S Acetate daily for ten days and then alternate days for a period of 30 days and then twice weekly for six months. Approximately two years later, this patient has had no recurrence of symptoms and no dietary restrictions including alcohol.

Mr. A.—age 62 has had gout for the past 12 years, with changes in joints. He did not respond to previous therapy. His uric acid at this time was 6.4.

Course and Treatment: On March 12, 1953 patient was placed on Reichstein's Substance S Acetate therapy (12.5 mg) intramuscularly per day. After the first two weeks this was reduced to four injections per week with one 10 mg. tablet of Reichstein's Substance S Acetate orally on the other three days. At present, which is six months later, he is free of his gout. He has followed no diet of any kind. His uric acid at this time is 2.2.

Mr. D. M.—age 48 was operated on in October 1949. The diagnosis of carcinoma of the liver was made. The patient was not expected to live more than four months. He has had an enlarged liver for the past eight years but was in fairly good health until about a year ago when he had a gallbladder attack with pain in the upper right quadrant and the right shoulder, a good deal of distention, diarrhea, clay colored stools and dark urine. He has sweated profusely all of his life regardless of time or temperatcre and always felt hot. He also had hay fever. None of the diseased tissue could be removed at operation. On July 19, 1950 he was hospitalized.

Laboratory Findings: Sedimentation rate 27, albumen was 7.43, globulin 3.33 or a ratio of 2.2, red blood count 6,010,000, white blood count 9.300, hemoglobin 13.5 grams. X-ray film of abdomen showed enlargement of the liver.

Course and Treatment: On July 28, 1950, after ten days of treatment with Reichstein's Substance S Acetate (12.5 mgs. daily), another X-ray film showed that the size of the liver had decreased, his symptoms abated, stools became normal, and there was no excessive sweating. At the end of three weeks, the patient left the hospital feeling quite well. He felt well until December 1950. In January he developed edema of the ankles, and edema of the lungs. Fluid was removed from the tissues and upon examination showed no change in the sodium and potassium. He died, of edema of the lungs on March 21, 1951. A Postmortem examination showed carcinoma of the liver. He had

been symptom free from July 1950 to December 1950 and remained alive to March 1951.

Mrs. A. M.—age 62 was seen on December 15, 1950, complaining of shortness of breath since November 1950 which required her to sit up at night. Her left arm had started to swell in August. She had known she had a cancer of the breast; but because of Christian Science beliefs, she did not have medical treatment until three weeks ago when she was already in the terminal stage. Physical examination showed a carcinoma of the breast with ulcerations extending to the axilla with an obnoxious odor and also a bloody discharge. The neck was swollen involving all of the glands. The left arm was three times its normal size. She was apathetic, semicomatose, unable to eat, and restless. X-rays showed involvement of the lungs and also of bony tissues, and metastases to other organs.

Laboratory findings: Red blood count 5,000,000; white blood count 11,000; hemoglobin 15 mg; sedimentation rate 15 millimeters in 60 minutes.

Course and Treatment: She was given 12.5 mg. Reichstein's Substance S Acetate daily from December 15, 1950 to March 24, 1951. Within three weeks the sedimentation rate dropped to 11, symptoms improved, and there was no discharge of blood from the wound. The patient was able to eat and sit up, and gained weight. On March 24 it was decided to drain the arm of its fluid. The patient was given an anesthetic, from which she did not recover, and died within 24 hours.

Mrs. C.—age 51 had metastatic carcinoma and had been given X-ray therapy and also had been given Krebiozen but she continued to deteriorate.

Course and Treatment: She was hospitalized June 1951 and treated with Reichstein's Substance S Acetate 12.5 mg. daily. During this entire period (four months) this patient became practically symptom free, she was able to retain food, had no pain, and had a better mental attitude. She died (October 1951). During the entire period, she was free of pain and psychic disturbances.

Mrs. V. S., age 45 has a history of lupus erythematosus for thirteen years which has become progressively worse, otherwise the history is essentially negative. She did not respond to previous therapy.

Laboratory Findings: Blood pressure 110/76, pulse, 76, red blood count 3,950,000, white blood count, 13,800, hemoglobin 12 grams, sedimentation rate 9 millimeters per hour.

Course and treatment: She was hospitalized on October 27, 1951 and remained there until November 10, 1951. She was given 12.5 mg. Reichstein's Substance S Acetate daily. Within two weeks after beginning therapy this patient's skin lesion had improved considerably, scales were lessened, the erythematosus almost disappeared, and she had a sense of well-being. Since then the patient has been receiving 12.5 mg. Reichstein's Substance S every other day and is improving. No side effects have been experienced during this six months period.

Mrs. T., age 33 has had lupus erythematosus of the nose and also several spots on her legs. She has been treated for many years without improvement.

Course and Treatment: She was placed on Reichstein's Substance S Acetate, 12.5 mg. daily for two weeks and then 12.5 mgs. three times per week. After three weeks of therapy the lesions on her legs completely disappeared, skin improved, scales became smaller. The patient has continued on Reichstein's Substance S Acetate treatment for the past four months without side reactions.

Mr. R. F., age 65 states he has had psoriasis since the age of 26. A month ago his hands and ankles became swollen, he also had pain and stiffness and was not able to be about. His general history was essentially negative. He was hospitalized March 21, 1951.

Laboratory Findings: Red blood count 3,500,000; white blood count 12,000; hemoglobin 11 grams; cholesterol 134.9; sedimentation rate 24 millimeters.

Course and Treatment: He was given 12.5 mg. Reichstein's Substance S daily. On April 15 his psoriasis was almost completely cleared, joint pain disappeared and he was able to be up and about. This treatment was continued for several months. At the end of three months he was free of symptoms, and returned to work. At the present time (May 22, 1952) there has been no recurrence.

Mrs. C., age 47 had generalized psoriasis covering face, neck, arms, back, and also scalp and ears for many years. She had not responded to any form of therapy.

Course and Treatment: We treated her with Reichstein's Substance S Acetate intramuscularly at 12.5 mg per day for four months. She began to improve within several weeks, and at this time most of her lesions had disappeared, with the exception of the ears which were swollen, oozing, and itching. She was then given an ointment of Reichstein's Substance S Acetate (1-1½%) to be applied several times per day, and in the course of several weeks, her ears began to clear, and at the present time the texture of the skin of the ears is as good as the rest of her body.

Miss W.—age 52. For the past six years, the patient had rheumatoid arthritis involving both hands. She had become progressively worse to the extent she has been hindered in her activities. For two years, she was given 20 mg. ACTH per week, but failed to respond. She was then placed on 25 mg. daily of cortisone for three months, with no response.

Course and Treatment: In November of 1952, she began treatment with ½ cc (12.5 mg) Reichstein's Substance S Acetate per day intramuscularly for 40 days. At the present time she is free of pain, although there were no changes in bone structure.

Mr. W. R.—age 26. Had atopic dermatitis since infancy, which disappeared without therapy at the age of two. At the age of 16 his dermatitis reappeared, and has been present ever since. During all of this period he has had migraine at two week intervals.

Course and Treatment: On September 16, 1952 he began treatment with 12.5 mg. daily of Reichstein's

Substance S Acetate intramuscularly for two weeks, then every other day for two weeks, and then twice a week. By January 8, 1953 the dermatitis had completely disappeared. This patient also states that since he received Reichstein's Substance S Acetate he has been free of migraine headaches with the exception of one very mild attack which did not require therapy.

Miss E. W.—age 36. Her symptoms began in 1932 with tightening of muscles in calves of legs. She was unable to move the legs without pain. In 1938 she began to have sensations of numbness in the right leg. About two years later, the entire left side of her face became numb, she was able to walk with difficulty. Her condition became progressively worse and in 1946 she was unable to walk without help. Her ailment was diagnosed as multiple sclerosis and she had been treated with histamine, quinine and physical therapy. She became gradually worse and finally became an invalid.

Course and Treatment: The patient has been on 12.5 mg. daily of Reichstein's Substance S Acetate since June 1952. At present, the patient states that she is able to move about more easily. She is also able to move the toes of the right leg which she was not able to do before. She has very little quivering of her legs. Prior to therapy she had to keep her feet flat on the floor to prevent tremors. She is able to lift her legs when walking and can balance herself without difficulty. Her weight has been the same. She maintains that she is a great deal improved in every respect and at no time have we observed any toxic effects.

Mrs. N.—age 50 has had almost daily attacks of migraine for 25 years with severe nausea and double vision.

Course and Treatment: She was given daily 12.5 mgs. of Reichstein's Substance S Acetate intramuscularly for a period of 2 weeks. Her migraine headaches were not as severe nor as frequent. The dose was increased to 25 mg. per day. She began to improve and was well controlled for several weeks. When treatment was discontinued her migraine returned with greater severity. Treatment was resumed and within 10 days she was free from headaches. This patient has been on this form of therapy for the past 6 months and only on rare occasion she would have a mild headache which did not require additional therapy. At no time during her treatment have we observed any side reactions.

Miss M. V.—age 58 has had bronchial asthma for ten years and has been treated without much relief.

Course and Treatment: She was hospitalized in October 1950 and was given 12.5 mg. Reichstein's substance S Acetate daily and symptomatic therapy. After two weeks she became asthma free and returned home. After a period of 16 months during which she continued to receive 0.5 cc (12.5 mg) Reichstein's Substance S Acetate every other day, this patient has become completely free of asthma, has gained weight, and has a sense of well-being, is never tired, and has at no time had any toxic effects.

Mrs. S.—age 60 has had bronchial asthma for the past eight years. Otherwise her history was essentially negative.

Laboratory Findings: Red blood count 4,690,000; white blood count 9,500; sedimentation rate 18; hemoglobin 96%; cholesterol 163.

Course and Treatment: She was started on Reichstein's Substance S Acetate; 12.5 mg. daily for ten days and since May 12, 1950 she has been receiving it twice a week. She has been completely free of asthma.

Mrs. D. A.—age 35 has had bronchial asthma for several years with poor response to any therapy. She spent most of the time in bed until she came to us in June of 1950.

Course and Treatment: The patient was placed on Reichstein's Substance S Acetate, 12.5 mg. daily, for a period of two weeks. During this time she became pregnant. When she was seven months pregnant she developed poliomyelitis. She continued to receive Reichstein's Substance S Acetate. She was delivered normally and has continued Reichstein's Substance S Acetate therapy since. She is still free of asthma and also has had a remarkable recovery from polio with but minor muscular atrophy of the right leg. She is now able to carry on her normal duties.

Miss B. V.—age 16 has had dermatitis since infancy. She was hospitalized and given cortisone for two weeks but was taken off because of side effects.

Course and Treatment: She was then put on Reichstein's Substance S Acetate, 12.5 mg. daily, and since Christmas 1951, she has been getting it twice a week. She has a sense of well-being and no itching. The dermatitis has almost cleared up and the patient has gained weight.

CONCLUSION

These observations indicate the relationship between the endocrines, the nervous system and disorganization of tissue function. The advantage that Reichstein's Substance S Acetate has over most other steroids is that it is relatively nontoxic. It is stated that none of the steroid hormones cure anything. This may well be correct. It has also been maintained that we are not certain how these substances work. This is true up to the present time. Since only a very limited amount of this steroid has been available up to date, it has not been possible to ascertain its specific merits accurately. It is precisely now that some orientation in this field is urgently desirable. However, it could be said that all steroid hormones seem to provide the constitution with a protective mechanism against stress and perhaps may lead toward a clearer concept as to the meaning of disease.

BIBLIOGRAPHY

John Peters, Clinical Results obtained with Reichstein's Compound, Ill. Med. J. 100, 249-251 (1951).

Louis River, Joseph Silverstein and Eugene Dolchede, The

use of Reichstein's Substance S in the treatment of cancer. Ill. Med. J. 104, 126-128 (1953).
Arthur H. Conley, M.D. (River Forest), Personal Communication (1953).
Chas. E. Franklin, M.D. (Oak Park), Personal Communication (1952).
H. M. Kass, M.D. (Chicago) Personal Communication (1953).
R. L. Kesler, M.D. (Oak Park, Personal Communication (1953).
R. C. Oldfield, M.D. (Oak Park), Personal Communication (1951).
A. Vandenberg, M.D. (Grand Rapids, Mich.) Personal Communication (1953).
James J. Walsh, M.D. (Oak Park) Personal Communication (1953).

« « « » » »

A Review of 202 Cases of Bacterial Endocarditis, 1948-1952

Melvin L. Afremow, M.D., Chicago

As new chemotherapeutic or antibiotic agents have been introduced into the therapeutic armamentarium many have been used in the treatment of bacterial edocarditis. To evaluate the effectiveness of the increased antibacterial spectrum as well as the knowledge of the need for larger dosage and prolonged treatment, a study was made of the incidence and mortality rate of the cases of bacterial endocarditis treated at the Cook County Hospital during the years of 1948 through 1952 inclusively. This is a 3300 bed general hospital servicing the medical needs of the Metropolitan Chicago area.

Excellent reviews of this disease have been published by Libman and Friedberg[1], Blumer[2], and Christian[3]. Kelson and White[4] reported on 250 cases studied between the years of 1927 and 1939 for the purpose of securing a basis of comparison with probable future therapeutic achievements. These authors pointed out that, "The separation of the term bacterial endocarditis into acute and subacute forms, according to the causative organism, the presence of a primary infective focus, and of previous heart impairment, the duration of the disease, the height of the fever, etc. is generally useful but by no means exact. The streptococcus viridans may cause a fulminating infection, and a usually virulent organism like the beta hemolytic streptococcus a lingering one. Subacute infections may rarely attack hearts without evidence of antecedent disease, and the bacteria of the acute variety may implant on unimpaired valves. Embolism sometimes kills abruptly after a few weeks or even days of a typical subacute course, and not infrequently fever spikes up to 105°F. in cases of endocarditis lenta. Designating the organism with or without the term acute or subacute is preferable to using one of the terms alone."

Reviewing the charts of a large series of cases indicated the need for rigid diagnostic criteria. Patients labeled subacute bacterial endocarditis were more correctly cases of fever of undetermined origin. The marked protean nature of the clinical course of this disease which can mimic almost any condition causing symptoms referable to an infection, endocardial and myocardial disease, and embolic phenomena which may involve any organ of the body, does make the diagnosis difficult in many cases. Additional confusion in the recognition of this disease may be caused by possible masking of the more common characteristic features of this disease by chemotherapy.

It was felt that the following diagnostic criteria formulated by Friedberg[5] would serve as a sound basis for diagnosis:

1. Persistent fever.
2. Valvular, or congenital cardiac lesions, or

From the Department of Medicine, Cook County Hospital and University of Illinois College of Medicine, Chicago, Illinois.

arteriovenous aneurysm as indicated by organic murmurs, bruit, and associated phenomena.

3. The appearance of new or change of pre-existing murmurs.
4. Embolic and vascular lesions, petechiae or Osler's nodes.
5. Positive bloode cultures.

To these should be added anemia, at the suggestion of Parsons et al[6,7] who observed anemia of a variable and often severe degree in 75 per cent of a series of 200 patients. They emphasize that the association of a cardiac murmur and an unexplained anemia or of an unexplained fever and anemia should suggest the possibility of bacterial endocarditis.

Most of the cases did not have all the criteria enumerated above. The lack of a positive blood culture constituted a sizable group of the cases reviewed; 25 per cent were in this category. There was a marked reluctance to make a definitive diagnosis without this bacteriological confirmation. As an example of this type, a resumé of a case is presented.

Case Report.—T.D., a 38 year-old colored male laborer, was admitted to the hospital on April 30, 1951. He complained of repeated colds during the past month, had lost twenty pounds of weight in a period of three months, had nocturia and polydipsia for the past six weeks, and right upper quadrant pain during the past week.

Past History: Pneumonia and acute arthritis in 1949. Gonorrhea and syphilis in 1949, for which he had treatment.

Physical Findings: Poorly nourished colored male, not acutely ill. Temperature 99.6°F., pulse 88, respirations 20, blood pressure 135 mm. Hg. systolic and 72 diastolic.

Heart enlarged of a mitralized aortic contour. Palpable diastolic thrill in the aortic and mitral valve areas. Loud blowing diastolic murmur over the aortic area transmitted to the neck. Loud systolic and diastolic murmurs at the mitral area transmitted to the left axilla. The liver and spleen were not palpable and no edema was present.

The admitting diagnosis was rheumatic heart disease with aortic and mitral valvular involvement, compensated, and possible subacute bacterial endocarditis.

Laboratory Findings: Blood count: red blood cells 3,010,000, hemoglobin 55 per cent, white blood cells 11,800, with a differential count of 83 per cent polymorphonuclear cells, 13 per cent lymphocytes and 4 per cent monocytes; sedimentation rate 26 mm. per hour. Urine showed 1+ albuminuria, sugar 0, 5-10 white blood cells, no red blood cells, and an occasional granular cast. Kahn test was positive on two tests.

Blood chemistry: Non protein nitrogen 26 mgm., total protein 7.6 mgm., glucose 96 mgm. per 100 c.c. of blood. Icteric index 4.

Roentgenogram of chest revealed cardiac enlargement in the transverse diameter with mitralization. Lung fields were reported as being clear.

Six blood cultures taken on admission and during hospital stay were negative.

Progress: Conjunctival petechiae and hemoptysis developed on May 6, 1951 and he was started on aqueous penicillin 300,000 units every three hours, a total of 2,400,000 units daily. Under this therapy he became afebrile and improved. However, a change in the character of the aortic diastolic murmur was noted. After thirty-one days of penicillin therapy he was discharged at his insistence.

Three days later, on June 9, 1951, he was readmitted to the hospital very acutely ill, with evidence of left and right heart failure. Despite treatment he expired June 16, seven days after the second admission. Blood culture taken during this period was likewise negative.

Necropsy Findings: Rheumatic fibroblastic deformity of the mitral and aortic valves. Rheumatic myocarditis. Subacute bacterial endocarditis of the aortic valve. Marked dilatation of the heart. Petechial hemorrhages into the epicardium. Acute pulmonary congestion and edema. The spleen showed recent infarction and marked follicular hyperplasia. Moderate chronic passive congestion of the liver. Old infarction of the right kidney and recent of the left, and acute proliferative glomerulonephritis.

In Table 1 are listed the yearly incidence of cases of bacterial endocarditis together with the number of hospital admissions. The autopsy numbers are included because the diagnosis of many of these cases, especially those with negative blood cultures, depended on the necropsy findings for confirmation. For the purpose of comparison two five year groups are included.

TABLE 1
CASES OF BACTERIAL ENDOCARDITIS

Year	Hospital Admissions	Autopsies	Cases
1943	58,161	1,282	96
1944	51,354	1,123	37
1945	53,730	1,226	43
1946	63,824	1,308	78
1947	71,909	1,310	90
Total	298,978	6,249	344
1948	70,384	1,389	68
1949	71,222	1,526	74
1950	69,271	1,199	38
1951	70,455	1,258	7
1952	69,988	1,229	15
Total	351,320	6,601	202

These statistics reveal a gratifying decrease of an average yearly incidence of 67 cases for the period of 1943-1947 to 40 cases for the 1949-1952 period, an over-all 46 per cent improvement. Littman and Schaaf[8], in a review of cases at the Massachusetts General Hospital, reported a reduction of 50 per cent in the incidence of cases during 1947 through 1949 compared with 1944 through 1946.

The apparent decreasing number of cases during recent years may be attributed to several factors, including the prophylactic use of antibiotics in cases of cardiac disease undergoing oral, genito-urinary, rectal or colonic surgical procedures, and earlier recognition and vigorous treatment of bacterial infections, and also more effective chemotherapeutic measures.

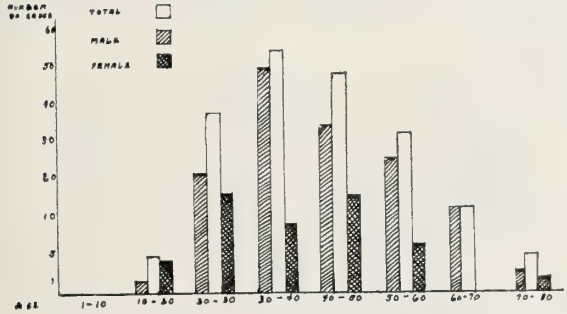
TABLE 2
INCIDENCE BY SEX

Male	151
Female	51
Total	202
Ratio male to female 3 : 1	

TABLE 3
INCIDENCE BY RACE AND SEX

	Male	Female	Total
White	116	25	141
Colored	35	26	61
Ratio of white to colored patients 2.5 : 1			

TABLE 4
INCIDENCE BY AGE AND SEX



As summarized in the tables, males predominated 151 to 51 cases, a ratio of 3 : 1. This compares with a 2 to 1 male sex preponderance reported by Kelson and White[4] and a 4 to 1 by Traut et al[9].

A racial incidence is reported since in this hospital there is an increasing number of colored patients and previous summaries of bacterial endocarditis have not included this differentiation. In this group of patients the ratio of white to colored cases was about 2.5 : 1.

TABLE 5
INCIDENCE BY SEX AND RACE IN THOSE BELOW THE AGE OF 40 YEARS

	Male	Female
White	54	11
Colored	19	16
Total	73	27

Above the Age of 40 Years

	Male	Female
White	58	14
Colored	14	10
Total	72	24

No age was available in six cases

That bacterial endocarditis may attack any age group is evident in Table 4, in which there are cases varying in age from 10 to 80 years, with the majority being in the third and fourth decades. Almost as many cases, 96, were 40 years or more as compared to 100 cases below the age of 40. The significance of the high incidence of this disease in older people is that the index of suspicion of diagnosis has a tendency to be less in this age group where the degenerative cardiac conditions are much more common. Zeman[10] reported 14 autopsied cases of subacute bacterial endocarditis in patients over sixty years of age and rheumatic heart disease in ten cases. Traut and associates[9], reviewing the autopsy records at Cook County Hospital for the period of 1935 to 1946, found 38 per cent of the cases of bacterial endocarditis over forty-five years of age. Of the ninety-four hearts examined in this age group, fifty-seven showed evidence of rheumatic scars.

TABLE 6
MORTALITY BY SEX

	Improved	Died	Mortality Per Cent
Male	49	102	67.5
Female	21	30	58.3
Total	70	132	65.3

TABLE 7
MORTALITY BY RACE AND SEX

	MALE		
	Improved	Died	Mortality Per Cent
White	34	82	70.7
Colored	15	20	57.1
Total	49	102	67.5
	FEMALE		
	Improved	Died	Mortality Per Cent
White	11	14	56.0
Colored	10	16	61.5
Total	21	30	58.3

TABLE 8
MORTALITY BY RACE

	Improved	Died	Mortality Per Cent
White	45	96	68.0
Colored	25	36	59.0
Total	70	132	

These tables reveal the very high mortality rate of 65.3 per cent with nearly a 10 per cent higher rate among males than females. Racially, the recovery rate was 9 per cent lower among the white patients as compared with the colored group. The mortality rate in this series is considerably greater than that reported by other authors. Littman and Schaaf[8] had a 30 per cent mortality rate, Friedberg[5] a 29 per cent rate and Lichtman[11] a 55 to 75 per cent recovery rate. Herrell[12] observed that if a suitable antibiotic or combination of antibiotics is employed and if the dose and duration of treatment are adequate, there should be a 60 to 70 per cent recovery. In a long term follow-up study of penicillin treated subacute bacterial endocarditis cases, Gorlin and associates[13] had a 70 per cent cure. A group of 269 cases, with positive blood cultures, adequately treated and carefully controlled bacteriologically had a 35 per cent death rate[14]. More recently, Keefer[15] considered that a 60-70 per cent recovery rate could be expected, and Donzelot[16] et al observed a 76 per cent improvement in a series of 202 cases.

The patients included in this study are probably not comparable with those treated in private institutions. They sought medical care late in the course of their disease, and after severe complications had ensued. The irreversible cardiac disability, massive cerebral and other embolic phenomena, overwhelming infection, and uremia caused death shortly after hospital admission. Therapy could not be expected to materially alter the course in these terminal cases. Fifty-three patients expired within five days of hospitalization. If this group is excluded from the 132 fatalities the corrected mortality rate would be 39 per cent with a recovery rate of 61 per cent. Unfortunately, a prolonged follow-up study on the surviving group was not possible.

The rate of improvement of patients with bacterial endocarditis seems relatively poor in the light of today's antibiotic and chemotherapeutic measures. Delay in taking and repeating blood cultures and reluctance to make a diagnosis without bacteriological findings caused inadequate treatment in many of these cases. In contrast to patients in other reported series, the patients at this hospital for the most part were poorly nourished because of economic reasons. Clinical experience has provided ample evidence that host factors alone practically never eradicate the infection of bacterial endocarditis. Durant[17] has stressed the nutritional factors in cardiac disease. Data has been presented by Axelrod[18] which would indicate that certain of the B vitamins, notably pantothenic acid, pyridoxine, and pteroylglutamic acid, play a significant role in antibody synthesis. In their absence, antibody production is markedly reduced.

Numerous different types of bacteria may be the cause of bacterial endocarditis to a great extent. The mortality rate depends upon the proper chemotherapeutic agent. For this reason a summary of the blood culture findings is listed in Table 9.

TABLE 9

Cultures	*Cases*	*Per Cent*
Positive	144	74.6
Persistently negative	49	25.4
None taken	9	

In the persistently negative series as many as eleven cultures were taken on a single patient. The average of this group of cases was about four. The mortality rate in the sterile blood culture group was almost twice that of the patients having a positive blood culture. Successful therapy is aimed at the destruction of all bacteria in the blood stream and especially the endocardial vegetations. This is a difficult prob-

lem as emphasized by Hunter[19], as one is dealing with a poorly vascularized vegetation composed of fibrils and necrotic valve substance in which masses of bacteria are growing, some in the depths where metabolic exchange with the antibiotics in the blood stream may be poor and where only a few leucocytes are present. In protracted cases a tendency toward healing by fibrosis and endothelization is often found in part of the vegetation. However, even in successfully treated cases this process reaches completion only after many months as has been shown by Moore[20] in a study of autopsy material from patients dying at various time intervals after cessation of therapy. There are many cases reported of clinically cured patients with repeatedly negative blood cultures who died from other causes but from whom at necropsy viable organisms were cultured from endocardial lesions. Cates and Christie[21] found that after death organisms may be cultured in 30 per cent of the patients in whom it was assumed that the infection was controlled.

The 144 cases with positive blood cultures is summarized in Table 10.

TABLE 10
BACTERIOLOGY OF CASES WITH POSITIVE BLOOD CULTURES

Organism	*Cases*	*Per Cent*
Streptococci, hemolytic and non-hemolytic, including the species salivarius, mitis and faecalis	127	88
Staphylococci, hemolytic and non-hemolytic	11	8.0
Diplococcus pneumoniae	4	2.5
Escherichia coli	2	1.5

The causative organism in the majority of the cases was a member of the streptococcic group. Staphylococci were the infecting bacteria in eight per cent of the patients. The organism was isolated repeatedly in each case so that the probability of a contaminant was not likely. Dowling[22] and associates have reviewed in detail 25 cases of staphylococcic endocarditis which, while not as frequent as the streptococcal type, is sufficiently common to warrant consideration. The literature[23,24,25,26,27] contains numerous reports on the increasing number of strains of bacteria especially staphylococci which are becoming resistant to antibiotics. Past experience has shown that as each new antibiotic is employed, strains of organisms within its antibacterial spectrum may be expected to develop resistance within several years. The number of resistant strains and their ability to withstand the action of the antibiotic are roughly proportional to the length of time in which the drug has been in use. Erythromicin, a new antibiotic, is especially effective against strains of penicillin resistant staphylococci[28,29] and its use in cases of staphylococcic endocarditis should be evaluated.

Blood cultures should be repeated frequently during the course of treatment of bacterial endocarditis. The period of treatment is necessarily prolonged to evaluate the effectiveness of the antibiotic being used, to detect possible resistant strains of bacteria or the emergence of new pathogens during the period of therapy. Too much confidence should not be placed on any antibiotic used, either singly or in combination, because of the marked variations in sensitivity exhibited by certain species of bacteria and the increasing tendency of some strains to become resistant to drugs employed at frequent intervals or for long periods of time.

SUMMARY AND CONCLUSIONS

1. Two hundred two cases of bacterial endocarditis were diagnosed among 352,320 hospital admissions during the five-year period of 1948-1952. This represents a reduction of 46 per cent from the years of 1943-1947.

2. The male sex predominated with 151 to 51 cases, a ratio of 3 : 1.

3. Racially there was a preponderance of white to colored patients, 141 to 61 cases or a 2.5 : 1 ratio.

4. Ages of the patients varied from 10 to 80 years of age, the majority of the cases being in the third and fourth decades.

5. Almost as many cases were over the age of 40 years as below.

6. The mortality rate was 65.3 per cent. However, 53 patients were admitted in critical condition and died within five days. Eliminating this group the mortality rate was 39 per cent. The recovery rate was 61 per cent.

7. Positive blood cultures were obtained in 74.6 per cent of the cases.

8. The streptococcic group of bacteria accounted for 88 per cent of the causative organ-

isms, and the staphylococcic group for 8 per cent.

1150 North State Street

BIBLIOGRAPHY

1. Libman, E., and Friedberg, C. K.: Subacute Bacterial Endocarditis, Oxford University Press, N. Y., 1948.

2. Blumer, G.: Subacute Bacterial Endocarditis, Medicine **II**:105, 1923.

3. Christian, H. A.: Determinative Background of Subacute Bacterial Endocarditis, Am. J. Med. Sci. **CCI**:34, 1941.

4. Kelson, Saul R., and White, Paul D.: A Review of 250 Cases of Subacute Bacterial Endocarditis, 1927-1939, Ann. Int. Med. **XXII**:40 (Jan.), 1945.

5. Friedberg, C. K.: Revised Criteria for Diagnosis and Treatment of Subacute Bacterial Endocarditis, Med. Cl. N. Am. 769 (May), 1950.

6. Parsons, William B., Jr., Cooper, Talbert, and Scheifley, Charles H.: Occult Subacute Bacterial Endocarditis Manifested by Hematological Abnormalities, Including Pancytopenia, Ann. Int. Med. **39**:2, 308 (Aug.), 1953.

7. Parsons, William B., Jr., Cooper, Talbert, and Scheifley, Charles H.: Anemia in Bacterial Endocarditis, J.A.M.A. **153**:14 (Sept. 5), 1953.

8. Littman, David and Schaaf, Royal S.: Therapeutic Experiences with Subacute Bacterial Endocarditis with Special Reference to the Failures, New England J. Med. **243**:248-252, 1950.

9. Traut, E. F., Carter, J. B., Gumbiner, S. A., and Hench, R. N.: Bacterial Endocarditis in the Elderly, Geriatrics **4**:205-210, 1949.

10. Zeman, F. D.: Subacute Bacterial Endocarditis in the Aged, Am. Heart J. **26**:661, 1945.

11. Lichtman, S. S.: Treatment of Subacute Bacterial Endocarditis, Current Results, Ann. Int. Med. **19**:787, 1943.

12. Herrell, Wallace E.: Antibiotic and Chemotherapeutic Agents in Infections of the Blood Stream and Heart, J.A.M.A. **150**:1450 (Dec.), 1952.

13. Gorlin, R., Favour, C. B., and Emory, F. J.: Long Term Follow-up Study of Penicillin Treated Subacute Bacterial Endocarditis, New England J. Med. **242**:995, 1950.

14. Christie, Ronald V.: Penicillin in Subacute Bacterial Endocarditis, Brit. Med. J. **1**:1 (Jan.), 1948.

15. Keefer, Chester S.: Present Day Treatment of Subacute Bacterial Endocarditis, J.A.M.A. **152**:139 (Aug.), 1953.

16. Donzelot, E., Le Bozec, J.-M., Kaufmann, H., and Escalle, J.-E.: Prognosis in Subacute Infectious Endocarditis Treated with Antibiotics: Results of Treatment in 202 Cases. Archives des Maladies du Coeur, Paris. **46**:97 (Feb.) 1953.

17. Durant, T. M.: Nutritional Factors in Cardiac Disease, Ann. Int. Med. **35**: 397 (Aug.), 1951.

18. Axelrod, A. E.: Effect of Vitamin Deficiencies upon Antibody Formation, The Merck Report **62**:17 (July), 1953.

19. Hunter, Thomas H.: Speculations on the Mechanisms of Cure of Bacterial Endocarditis, J.A.M.A. **144**:524 (Oct.), 1950.

20. Moore, R. A.: Cellular Mechanism of Recovery After Treatment with Penicillin: Subacute Bacterial Endocarditis, Tr. and Stud. Coll. Phys. Phila., **14**:55, 1946.

21. Cates, J. E., and Christie, R. V.: Subacute Bacterial Endocarditis: Review of 442 Patients Treated in 14 Centres Appointed by Penicillin Trials Committee of National Research Council, Quart. J. Med. **20**:93, 1951.

22. Dowling, Harry F., Lepper, Mark, Caldwell, Eston R., and Spies, Harold W.: Staphylococcic Endocarditis: An Analysis of 25 Cases Treated with Antibiotics, Together with a Review of the Recent Literature, Medicine **31**:155 (May), 1952.

23. Rantz, L. A., and Randall, E.: Antibiotic Synergism and Staphylococcus Aureus, Antibiotics and Chemotherapy **2**:645, 1952.

24. Jawetz, E.: Antibiotic Synergism and Antagonism, Review of Experimental Evidence. Arch. Int. Med. **90**:301, 1952.

25. Eagle, H., Fleischman, R., and Levy, M.: Development of Increased Bacterial Resistance to Antibiotics. 1. Continuous Spectrum of Resistance to Penicillin, Chloramphenicol and Streptomycin, J. Bact. **63**:623, 1952.

26. Koch, M. L., and Bourgeois, R. W.: Report of a Further Increase in the Incidence of Drug-resistant Pathogenic Staphylococci Encountered in the Hospital Laboratory, Antibiotics and Chemotherapy **2**:229, 1952.

27. Dowling, H. F., and Lepper, M. H.: Practical Problems in the Use of Antibiotics, Med. Cl. N. Am. **36**:247, 1952.

28. Finland, M., and Haight, T. H.: Antibiotic Resistance of Pathogenic Staphylococci, Arch. Int. Med. **91**:143, 1953.

29. Haviland, James W.: Advances in Antibiotic Therapy, Ann. Int. Med. **39**:3-7 (Aug.), 1953.

‹‹‹ ›››

The prevention of infectious hepatitis

Gamma globulin in a dosage of 0.01 cc. per pound of body weight was given to alternate members of 40 families, in each of which a sporadic case of infectious hepatitis had developed. Only one case of hepatitis occurred among 38 exposed adults and 57 exposed children who were given gamma globulin, Jaundice was noted six days after injection in that case. In comparison, secondary cases appeared in two out of 55 exposed adults (4 per cent) and 11 of 40 exposed children (27 per cent) who were the untreated controls within the same families. Administration of 0.01 cc. per body weight appears to be as effective as that of 0.1 cc. in preventing the spread of infectious hepatitis within family groups. *David Yi-Yung Hsia, M. D., et al. Gamma Globulin In The Prevention Of Infectious Hepatitis. New England J. Med. Mar.* 11, 1954.

Emotional Aspects of Allergic Manifestations

Irving L. Turow, M.D., Peoria

IT is a common failing of many of us who are engaged in the specialties to focus primary attention to the specific factors, symptoms, and pathology in the patient as they relate to the type of disease entities which we have particular aptitudes, training, and experience to treat. It is clearly understandable then that the allergist in his attempt to study and treat his patients presenting allergic problems will do so on the premise that most individuals present signs and symptoms of allergic reactions resulting from disturbances of body immune reactions and physiochemical changes due to specific allergens. This premise is obvious to the allergist since the preponderance of his training and experience has come from knowledge and studies to corroborate these basic principles which have achieved acceptance as primary causes of allergic responses. This may, perhaps, explain why emotional factors as concomitant influences or precipitating causes in allergic manifestations have not received as much consideration as we believe they should. If one is trained primarily to think in terms of organic response to specific chemical or physical substances, then the importance of "emotional allergies" does not seem to merit much consideration. If our attention is called to the marked autonomic nervous system changes which occur under circumstances of fear, rage, and anxiety, we will agree that physiochemical changes of rather marked degree can occur under influences of non-organic stimuli; i.e., emotional stimuli — known or overtly unknown, can and do produce symptoms of organic disease or dysfunction.

Gottlieb[1] in his review of recent literature concerning bronchial asthma states that "altho the recent literature is replete with reference to the psychiatric aspects of asthma — it is probably not unfair to say that little has been added to the formulation of French and Alexander in 1941." Gottlieb goes on to state that "In a psychosomatic study of 129 asthmatics, Schwoebel[2] found some psychogenic component in all; thirty-six spontaneously reported emotional experiences as the precipitating cause of their first attack and twenty-eight others recalled such during the anamnesis; seventy-eight stated that subsequent paroxysms were precipitated by conditions of psychogenic character. Prevalent character traits included fear, deepseated anxiety, egocentric tendency, feelings of insecurity, unusual attachment to mother or equivalent person, irritation, and moodiness." An underlying theme, thruout the literature, is the fear of loss of, or separation from, the mother or the loss of her love.

It is not the purpose of this paper to stress which is primary — allergy or emotional factors. It is our purpose to substantiate and call increasing attention to the thesis that many patients with allergy do have emotional problems and that recognition and treatment of their total problems will aid in more favorable response to treatment for their allergy. In some instances, the allergic manifestations occur as a result of emotional stress and properly directed psychiatric treatment can create either an emelioration or resolution of the allergic symptoms. It is agreed that in the majority of instances the allergic manifestations are due to specific chemical or physical substances — but that these responses can be intensified by emotional stress experiences. In other instances, relief of the allergy due to specific physical or chemical

1. Gottlieb, Philip M.,: Bronchial Asthma: A Review of the Recent Literature, Annals of Allergy, 11: 367-410 (May-June) 1953.

Presented before the Section on Medicine, Illinois State Medical Society, 114th Annual Meeting, Chicago, May 20, 1954.

2. Schwoebel, G.: Psychosomatic Studies on Bronchial Asthma: The Character Structure of the Asthmatic. Am. J. Psychotherapy, 6: 214-216 (Jan.) 1952.

agents can be accomplished in the treatment of the allergy only after the emotional factors have been recognized and the patient treated for the emotional problems involved.

It is our belief that in those instances where allergic disturbances occur in individuals who have emotional disturbances that a study be made of the individual including all phases of his disturbed responses rather than to focalize only on one phase of his dysfunction manifestations.

It was because of this interest in the complementary relationship of the psychological and allergic factors which led Dr. Leonard Harris, my allergist colleague, and myself to collaborate in the studies and treatment of the present series of patients which are being discussed in this paper.

STUDIES

Patient John P., age 29, married, was referred by the allergist for investigation and treatment of an emotional disorder which was felt to influence the progress in treatment of hay fever, five years duration, and asthma of three years' duration. He was under treatment by Dr. Harris for a period of one year.

This individual was of asthenic habitus, presenting complaints in the initial interview of occasional precordial distress, frontal headaches, nuchal soreness, vague pulsating experiences in the abdomen, fear of dying, and fear of having organic heart disease.

The neurologic examination was essentially normal in respect to responses to clinical examination of the brain and its component parts, spinal cord, and peripheral nervous system. Autonomic dysfunction was present as observed by a moderate degree of hyperhidrosis and vasomotor liability. He was moderately tense, had an anxious facial expression, appeared restless and ill at ease.

His father died of a coronary thrombosis two years previously at age 65, and mother was living at age 63 in good health. The patient was one of nine siblings, seventh in order of birth. The mother was described as a very strict person, the father more lenient. None of the family were demonstrative in their affections.

The patient was enuretic until age of 7. During early childhood, he recalled entertaining feelings of inferiority regarding his physical acumen. He was particularly sensitive about the size of his penis which he felt was under-developed, and recalls being called "Long John" in a derogatory manner by his friends—they inferring that he had a small penis. Although he was a good student scholastically, he was asocial, shy, and withdrawn. A considerable degree of rivalry existed between the patient and his younger brother of whom he was envious because of the younger sibling's ability to be more aggressive and better accepted in his relationship with friends. Intermittent diarrhea was frequently experienced by the patient as a child under circumstances of emotional stress. Masturbation was begun at age 13 or 14, and he recalls when once told by the high school coach that masturbation would bring on heart trouble—a tremendous degree of guilt and fear of heart disease would accompany the act subsequently. His relationships with members of the opposite sex were exceedingly limited during high school days because of his feelings of inadequacy concerning his masculinity.

The patient was married for 5½ years and had one child, a boy, age 4. His wife was described as an aggressive person, who following their marriage, frequently referred to her unhappiness because she could no longer pursue her educational interests because of her home duties. It was following the marriage that an intensification of the emotional symptoms and aggravation of his hay fever and asthma became manifest. He noticed that both his emotional symptoms and asthmatic symptoms would become aggravated when he was engaged in any type of competitive activity with his wife. They played tennis frequently and especially when she would be gaining in the score he would be prone to become very dyspneic and apt to experience an asthmatic attack associated with frontal headaches and gastro-intestinal discomfort.

Psychiatric investigative studies of the dynamics of his emotional disorder were conducted with the aid of sodium amytal. As the interviews progressed and he became acquainted with the underlying factors producing the emotional reactions, he began to experience a progressive amelioration of all symptoms. As the causes were understood, directive therapy was employed and under partial guidance the patient began to develop a more wholesome relationship with his wife, eventually feeling more adequate and independent. It was interesting to note that as his emotional adjustments became adequate, there was a proportionate improvement in his asthmatic symptoms.

In this individual, aggravation of allergic symptoms became manifest under conditions of emotional duress. He entertained marked feelings of inadequacy and inferiority since childhood. He was uncertain of his masculinity, grew up, as the history revealed, under a dominant mother. "My mother," he told the psychiatrist, "expected her children to stand up on their own feet. I receive little support from her."

In his marriage he again had to deal with a dominant female who put him in a dependent role and who was dissatisfied with her marital circumstances. This dependency upon his wife, which was wanted unconsciously, was distasteful to him consciously.

When she showed her dominance and overshadowed him in competitive situations, such as participation together in a game of tennis, the frustration and anxiety associated with the situation, precipitated or aggravated an asthmatic attack.

Under combined therapy with allergist and psychiatrist, greater improvement in symptoms soon became manifest. Eventually resolution of asthmatic symptoms occurred.

Patient: Mrs. B., age 25, married 5 years, gave no history of asthmatic attacks until about six months after her marriage when she began to have episodes of wheezing, which investigation revealed would occur following situations in which she became emotionally perturbed. At one time she saw a physician elsewhere who tested her for reactions to various antigens but was unable to obtain any positive response to any of the substances with which she was tested. Prior to referral for psychiatric study, she was skin tested by Dr. Harris with negative results. In his first examination, the lungs were reported as hyperresonant, and there were dry expiratory rales which cleared after the injection of epinephrine 0.30 cc.

When seen in the first psychiatric interview, the patient presented symptoms and findings of anxiety —her face tense, her hands tremulous and moist, her mood depressed. Symptoms of insomnia and marked irritability were complained of by the patient.

The background history was significant in that it revealed a longstanding pattern of neurotic behavior since childhood. She early became resentful toward her mother partly because that parent favored a sister who was permitted more outlets and less restrictions than herself, and, mainly, because the mother treated the patient with rigidity and inadequate degree of affection. She would not allow the patient to develop friendships unless the child's choice met with the mother's approval. As a result she had very few friends. During the patient's adolescence her parents owned a grocery store and here again she was imposed upon by the mother, insisting the patient work at the store while "my lazy brother would go away on trips." The father was an indecisive, passive person who permitted himself to be dominated by his wife. Throughout the history, evidence of maternal rejection was present.

The patient freely admitted that her marriage was not one of choice, but one of escape. She stated, "When we were engaged I would tell him—let's get married so I can get away from my mother." These facts are noted to indicate the marked hostilities and conflicts which developed and were present in this patient prior to a marriage which she felt would release her from the circumstances of subjugation, lack of love, and understanding.

She, however, was subjected to increased frustration following marriage when she realized she married a person who showed little affection or interest toward her and from whom she could obtain no affection, understanding, or wholesomeness in relationships which she yearned for through the years. It was in this state of increased frustration that asthmatic symptoms became manifest.

On each occasion when her husband would evince his rejection of her, an asthmatic attack would follow. When her one close friend passed away, she had episodes of sighing dyspnea. Whenever she engaged in an argument with her mother-in-law, who also rejected her, she would begin wheezing and become dyspneic. The mother-in-law tried to prevent the marriage from materializing by deriding the girl in discussions with her son before he married Mrs. B.

On one occasion the patient related that she was wheezing for several days prior to her husband's departure from the city and while he was away for two days she said, "I felt fine—I had no asthma at all." Soon after his return, however, the symptoms reappeared.

Only three interviews were held with the patient and because she resisted further investigation and treatment, therapy could not be continued. It is interesting, however, that the patient claimed she was beginning to feel better by the third interview.

In this instance we feel that sufficiently valid evidence was obtained to indicate a precipitation of asthmatic attacks by emotional causes, which were primarily related to maternal rejection and principally came to the fore following a marriage in which she anticipated substitutive emotional compensation, but upon being further traumatized emotionally with frustration by her husband, developed asthmatic symptoms.

Patient: Harlan McD., age 7, white male, gave a history of asthma since the age of 5. He had a proven clinical sensitivity to soybeans, peas, dust, and ragweed, and had been reasonably well controlled under allergic management for one year when the clinical picture underwent a change. For about six months prior to the initial psychiatric interview he had nocturnal attacks, characterized by awakening from his sleep, manifesting marked anxiety, crying out and frequently shouting, "Quit—don't do this, don't do this." The attacks were associated with coughing, followed by pronounced wheezing. His father would rush to his bed, apply a cold towel to his chest, and with reassurance the attacks would cease.

The patient was one of three siblings. His sister, 21 and brother, 19. His mother, in giving the history, impressed the psychiatrist as a rather rigid individual who gave only verbal concern regarding the patient's welfare. The father appeared more tolerant and understanding.

The child was a very alert youngster, having superior intelligence. He verbalized surprisingly well and related himself excellently to the psychiatrist.

In the investigation of the emotional difficulties

experienced by the child, we learned of a marked fear of the dark which had been present for three years. At the age of 4 he had a traumatic experience one night when his parents went out leaving him in the care of his sister. She left the light on in his room and in order to cut down on the glow, placed some cloth over the lamp which caught fire and ignited his bedclothes. For a long period of time subsequently he did not want to sleep in his bed.

His brother, it was later revealed, had for a number of years obtained a sadistic delight in taunting him sneaking up behind the patient and making weird noises. In one of the interviews, the patient said, "I'm afraid of the dark, that's one thing I'm really afraid of. I want to keep myself safe. My brother started it before he went into the army—he started making noises like a tiger to scare me. I think there's ghosts in the dark and when I go to bed I'm afraid. My brother sometimes says there's a ghost in the kitchen. The curtains in my room make me scared—they move around like ghosts. I'm even afraid of the toilet—I'm afraid a hand might come up and pull me in." (Mother and father advised the psychiatrist that the patient would not go to the bathroom at night unescorted.)

In subsequent interviews, the patient was given assurance, understanding, and support. The attacks became ameliorated and one month after therapy was begun the mother reported that he was sleeping well each night and was not having any attacks of anxiety or asthma during the night.

Patient: Imogene R., age 27, female, married, a school teacher, was referred by the allergist after his studies revealed no allergic basis for generalized urticarial episodes which recurred intermittently during a six-month period.

This individual was a well-nourished, attractive, vivacious appearing person who stated that she first had a generalized urticaria at Christmas time when she was visiting with her family in Wisconsin. Since then she observed that under conditions of emotional duress she developed "crops of hives" occurring "most anywhere on the body." Further investigation revealed concomitant symptoms of sleeplessness, irritability, nuchal soreness, hyperhidrosis, morning fatigue, occasional frontal headaches, and gastrointestinal distress. During the preceding four months, she reported, she had been stuttering on occasion.

The patient was married to a man two years her junior, an engineering student at a local university. She had a miscarriage one year previously, after three months of a pregnancy which was not planned for. She did not want a family as yet because of the insecure economic situation—her husband being dependent upon government aid to help him through college.

In investigating the circumstances present at the time of the initial eruption, we find that her sister had a baby during the Christmas holidays and the entire family made much to do about the event, placing the patient in a very secondary position at that time. Further elaboration about the relationship between the patient and her sister revealed that the patient had been very envious of her, especially since the sister married a successful man who was able to provide the sister with many comforts the patient herself considered she was deprived of. In addition, the patient was rather disappointed in her marriage and had become increasingly malcontent with her husband whom she felt was not as aggressive and forceful as she had hoped he would be. This state of malcontent frequently led to petty arguments during which periods she was likely to develop an urticarial reaction.

The patient had a basic compulsive obsessive personality pattern and when she did not reach the degree of success or accomlishment in any important endeavor, she would frequently have an episode of depression of mood and experience physical symptoms already described.

Two diagnostic interviews were held with the patient. She was seen during the early summer and had already planned to spend time during the ensuing months with several members of her family out of town. During these interviews the inter-relationship between the factors causing emotional duress and the resultant physical experiences were carefully discussed. She quickly gained insight into her problems and noted a rapid resolution in the presenting complaints.

Although she was not seen subsequently, a recent report from the patient revealed that she has not had any return of the urticaria and states that with the dynamics which she now understands, she will be able to work out her problems in a much better manner, since she is now aware of the problems creating her distress and with this knowledge is able to cope with her circumstances more effectively.

CONCLUSIONS

We have attempted to emphasize that greater consideration should be given to the complementary relationship between psychological and allergic factors in the etiology of bronchial asthma and other allergic states. We wish to confirm that in most cases asthmatic attacks are precipitated by allergic factors alone; in others, the combination of allergic and emotional factors produce the attacks; in a few others, the attacks may be precipitated by emotional factors alone.

In the cases presented, definite factors were uncovered to verify the influence of emotional disturbances on the allergic manifestations. In two, the allergic manifestation appeared to be primarily a response to conflict which the individuals were unable to cope with until they

gained insight into their problems, and when thru such therapy they were consciously able to adjust to their conflict — amelioration or resolution of allergic symptoms resulted.

These studies, in our opinion, indicate the greater need for collaborative work between the allergist, others treating allergies, and psychiatrist — doing so with the basic consideration that each has an equally important role to play in the treatment program. If we combine our skills and experiences under this basic premise, more fruitful results can be achieved in the treatment of our patients who call upon us to exercise our knowledge in helping them attain both bodily and emotional well-being.

331 Fulton Street



Looking Forward In PUBLIC HEALTH

Roland R. Cross, M.D., Springfield

ALTHOUGH the title of my remarks is "Looking Forward in Public Health" I think it would be helpful at the outset to glance backward. So, I should like to remind you that on July 12, 1952 the State's official public health agency was 75 years old. At the time of its birth on July 12, 1877, the State Board of Health had little upon which to build a program of disease control and prevention except hope and enthusiasm. Such things as yellow fever, cholera, diphtheria, smallpox and typhoid fever were abroad in the land and the people didn't like it. They were against epidemics. So were the doctors. Led by the Illinois State Medical Society, the people resorted to the good old American way of solving social problems — they passed a law.

As is so often the case, concerning legislation, that law, the State Board of Health Act, was an expression more of hope and desire than an article of faith and great expectations. Indeed it could not have been otherwise. There were theories and speculation in plenty, but little solid knowledge on how to prevent diseases. The General Assembly recognized this situation for exactly what it was. As evidence of that fact only $5,000 was appropriated to finance the new creature during its first two years of life. The language of the law, moreover, conferred sweeping powers on the Board while prescribing its functions as to disease control in terms both vague and general. Indeed only 100 of the 1,200 words employed in the original State Board of Health Act were used to define the duties and responsibilities of the Board in the control of diseases. I think these 100 words are worth repeating here. They read as follows:

> "The State Board of Health shall have the general supervision of the interests of the health and life of the citizens of the State. They shall have charge of all matters pertaining to quarantine; and shall have authority to make such rules and regulations, and such sanitary investigations, as they may from time to time deem necessary for the preservation or improvement of public health; and it shall be the duty of all police officers, sheriffs, constables, and all other officers and employees of the State, to enforce such rules and regulations, so far as the efficiency and success of the Board may depend upon their official cooperation."

Here was a bold venture into an uncertain future aimed at solving intolerable health problems. The wisdom of that enterprise is now well known history. In looking backward today it seems as though the State Board of Health was

Presented at the General Session of the Illinois State Medical Society, Chicago, May 21, 1953.

created as a result of subconscious anticipation of discoveries which the future would unfold. There appears to have been a compelling notion that if machinery for fighting epidemic diseases were created, the means for its successful operation would be forthcoming as time went on. At the very least this official agency created primarily to combat epidemic diseases would have a wholesome psychological effect. Whatever their hopes and aspirations the public health movement in Illinois and elsewhere has fulfilled all expectations in full measure.

I should like at this point to explain my conception of public health service. Important as it is the official public health department, whether local, state or federal, delivers only a part of the public health services of the community and the nation. Doctors, dentists, nurses, engineers, educators, hospitals, various voluntary agencies and all others who contribute deliberately to the prevention of disease and the improvement of health are delivering public health service. The official public health agency, if it fulfills its responsibilities properly, provides leadership in this important field. The ideal health officer should be able to set in motion the machinery to solve any health problem that arises in his community which is validly a public responsibility. He should be a man of parts whose personality and qualifications command the respect and confidence of the professions and the public alike. He should be an outstanding personage in his community by reason of merit. The health department proper need not necessarily be very large. It should be prepared, however, to give guidance in public health matters and to draw on all community resources for the solution of problems which are community responsibilities. Training and research are important functions of official public health agencies.

Now let us examine briefly the public health situation today and look forward, in confident anticipation if you please, at what may be ahead over the horizon. There is, of course, some unfinished business with respect to diseases such as tuberculosis and syphilis which have come already under the ban of official public health departments. There are such perplexing problems as "polio" and "flu" which command the attention of health officers everywhere and challenge the ingenuity of man as yellow fever once did. Diarrhea of the newborn, especially in maternity hospitals, is an important piece of unfinished business which requires great alertness on the part of public health officers both as to control and in the realm of research. The outlook as to fairly rapid progress against this group of diseases appears to be most promising.

The new business, the things to come, which challenge preventive medicine today as yellow fever and cholera challenged it 75 years ago include, as medical problems, two things in particular. These are mental diseases and chronic diseases. I single out for special notice these two groups because they are responsible for a tremendous and growing burden on our society which may be approaching the maximum toleration point. With respect to the magnitude of the mental disease problem I need mention only that upwards of 51,000 patients crowd the State's mental hospitals to overflowing and the rate of admissions in recent years has steadily run ahead of discharges. In 1945, for example, the patient load was only about 45,400. I need scarcely mention, moreover, that mental and nervous abnormalities are responsible for a large share of medical practice and for much delinquincy and crime.

The State of Illinois is now operating on a billion-dollar biennial budget. About 10 per cent of that money goes to the Department of Public Welfare. Most of that Department's expenditures go for the care and treatment of mental patients. The construction of new hospital facilities by the State although rapid, has not kept pace with the need to house adequately the mental patients committed to State institutions. A considerable proportion of the hospital facilities constructed and operated by non-governmental agencies is devoted to the care of mental patients and the demand for such facilities is increasing.

Whatever psychology and psychiatry has done to alleviate mental illness, one thing is crystal clear. The basic causes of many mental diseases have not been found. We are still in the dark in that respect. We need almost desperately to know how to prevent mental disease. To be able to prevent, we must know the causes.

When the State Board of Health was organized on July 12, 1877, those responsible for that law knew nothing about the basic causes of such diseases as yellow fever, cholera, typhoid fever,

diphtheria and malaria. They knew only that these and other epidemic diseases had come to be intolerable and that something ought to be done about it.

We are now in much the same situation with respect to mental illness. The challenge is before us. All the ingenuity that scientific minds can muster is needed to find a solution of the problem. The practicing physician, the men and women in our laboratories, the voluntary agencies and those engaged in official public health service have an opportunity to contribute toward the goal ahead. The organization of outright research teams to examine unexplored approaches to the causes of mental illness would be an investment of the highest order.

With respect to that conglomerate group of ailments known collectively as chronic diseases, which are responsible for a vast amount of disability, we face a problem as complex and large as that caused by mental illness. Not only so but the problem grows larger day by day. Somewhat ironically, the very successes of preventive medicine heretofore have been a major contributing factor in bringing about the appalling magnitude of the chronic disease problem. This burden is on our doorstep by our own doing. We have saved life among the young who now are plagued with the disabilities invited by advancing age. As advocates and practitioners of preventive medicine we are doubly responsible for pressing toward relief from chronic disease.

Evidence of what chronic diseases are doing to society is not far to seek. Death records reveal that three-fourths of all mortality is attributed to chronic diseases while 90 per cent of absence from work is attributed to non-occupational illness or accidents.

The nursing home industry, moreover, is growing at a rate not unlike the motel business a few years ago. In Illinois, for example, there are now approximately 600 licensed nursing homes which house an aggregate population of approximately 20,000. A number of other somewhat similar institutions housing several thousand people are located in this State. Most of these people are permanently unproductive. Doubtless many more in like condition are housed at their homes.

Of course effective work against chronic diseases is being done and it is improving. The specialty of physical medicine is growing and treatment centers are being organized with increasing frequency. The official rehabilitation services are yielding astonishing results. In Illinois, for example, the Division of Rehabilitation provided services in 1952 to *4,049* disabled adults which resulted in lifting their earning power from an average of about $600 to $2,500 per year. The total net gain in productivity of this group was over $7,000,000.

This illustrates what can be done and is being done as a salvage operation. The great need, however, is prevention. Here again is a boundless field for research. One approach to fruitful research would be an exhaustive study of the health status of a typical segment of the population. We have no comprehensive data on prevailing health conditions in the population. An intensive study of all the people in a county or two in northern Illinois and likewise in southern Illinois would yield information that might be of the highest value as a guide to research. There are many other avenues of approach. The important point is that action commensurate with the importance and size of the problem be taken. Courage, enthusiasm and resources are needed for this purpose.

Another field which needs more attention in the future is that of atmospheric pollution. The growth of industry and the continued trend toward concentration of large populations in small land areas adds constantly to the importance of polluted air as a factor in health. We have had a few warnings of what high concentrations of atmospheric pollution can do to a population under unfavorable weather conditions. The experience at Donora, Pennsylvania, a few years ago was one such episode. Another took place more recently in London. The excess mortality attributed to atmospheric conditions in London during one week of December 1952 was higher in proportion to the population than was the excess mortality from cholera in that city during the worst week of the great epidemic in 1866. It may well be, moreover, that polluted air is responsible for a considerable amount of chronic diseases such as cancer of the lung and other respiratory ailments. Dirty air at best causes a substantial economic loss. For all of these reasons the atmospheric envelope of our cities offers a fertile field of research from the

standpoint of public health and that field has been scarcely touched in this respect.

But what of the cost, you ask. Can we afford to go on and on and on with research and service in the fields of medicine and sanitation. My reply is that our resources in man power and mechanical facilities are far more abundant than ever before. Not so long ago 80 per cent of the people in America were engaged in agricultural pursuits and animal husbandry. That was necessary to produce an adequate food supply. Today agriculture and animal husbandry require only about 20 per cent of the population to meet the food requirements of the nation and more. Much the same can be said about the developments in industry. The essentials of life, food, shelter and clothing can be produced in adequate supply through the efforts of a smaller and smaller proportion of all the people.

This releases a great and growing reservoir of manpower for other pursuits. For what better purpose can this reservoir be drawn upon than to make life healthier and create an environment conducive of better living?

The best that humanity has to offer is needed in the broad field of preventive medicine. The medical profession has been a major influence in the establishment and development of what is known as the public health movement in the United States and elsewhere. That movement has now reached worldwide dimensions. The direction which the official components of this movement will take and the effectiveness with which these agencies perform their functions will depend very largely upon the quality, the character and the numerical strength of the men and women employed. There is much to be done in preventive medicine by both government and private enterprise. They must work together to achieve success. The medical profession has before it an unparalleled opportunity to provide the leadership as well as the physicians who are so desperately needed to fill in the ranks of professional talent which the situation requires.

‹‹‹ ›››

Eczema is allergy

Why is it important to treat these babies with eczema as an allergic child instead of a skin disease? In a study we made of allergic children from birth to adolescence, we found some interesting facts. Eighty of 100 babies that were allergic in infancy developed some form of major allergy as they grew to puberty; 60 of this 100 developed allergic rhinitis of the perennial type; 33 per cent developed seasonal pollen hay fever; one out of four (25 per cent) of these allergic infants later developed asthma and one of three had chronic eczema; 20 percent has chronic gastrointestinal symptoms; 10 per cent had urticaria or angioedema; about 2 per cent developed migraine headaches. The remaining 20 per cent of this group (20 patients) developed minor allergy that was not of too much consequence. In the known allergic infants, the active prophylactic measures that were instituted for their allergic symptoms enabled these children to grow and lead normal lives. Although many of the treated allergic infants did have allergy of one sort of another as they grew older, symptoms were mild and of short duration, and not disabling. Those who were not treated for their allergic disease were the group known as "allergic cripples," who were and are partially incapacitated. *Norman W. Clein, M.D., Recognition and Management of Allergic Symptoms in Infants. Rocky Mountain M.J., Nov. 1954.*

GLUCAGON

S. O. Waife, M.D., Editor, Journal of Clinical Nutrition.

SEMINAR
of the Department of
Medicine of the
University of Illinois
Edited by:
Dr. Max Samter
Associate Professor
of Medicine
Dr. Alexander Remenchik
Clinical Instructor in
Medicine

Dr. S. O. Waife (Editor, Journal of Clinical Nutrition)

Perhaps we should introduce the subject of glucagon by a brief historical survey. When insulin was first isolated, it was noted that the intravenous administration of the first preparations produced a transient hyperglycemia. Kimball and Merlin coined the name "glucagon" for the hypothetical substance present in the initial insulins that was responsible for this effect. Following the crystallization of insulin by Abel, no hyperglycemic effect was noted in this purified insulin. Therefore, interest in this "contaminant" was lost until 1934, at which time, Scott prepared a new crystalline insulin which did have a hyperglycemic effect. There were conflicting reports regarding these phenomena until 1945. It was then noted that certain European, especially Danish, insulins did not produce this hyperglycemic effect, whereas American preparations of insulin did. Interest was rapidly reawakened in the subject and culminated in the work of Staub at the Lilly Research Laboratories, who isolated crystals of glucagon in 1953.

At this point, perhaps we can go ahead and discuss briefly, some of the chemical characteristics of glucagon. It is a protein, probably of small molecular weight, approximately 4,000. Various studies have shown that in amino acid content and in the reaction to trypsin glucagon and insulin are two totally different compounds and, that glucagon is not a metabolic product of insulin. Electromicroscopy has shown that glucagon does resemble insulin morphologically. Sutherland has found that it is present in the upper two-thirds of the gastric mucosa and in the pancreas. In the pancreas, the concentration parallels the islet concentration, i.e., it is high in the tail of the adult pancreas and in the fetal pancreas.

Since alloxan destroys the beta cells but does not apparently affect glucagon, it has been postulated that glucagon is produced by the alpha cells in the islets. In addition, it has been noted that cobaltous chloride produces changes in the alpha cells and administration of cobalt may result in a transient hyperglycemia.

The action of glucagon has been fairly well worked out. It is evident that its sole function is to act on liver glycogen alone. Apparently, it activates a phosphorylase enzyme system. Those enzymes facilitate the conversion of glycogen to a hexosephosphate, that is, glucose-1-phosphate.

We have been interested particularly in the comparison of the action of glucagon with that of epinephrine. Both substances produce a fall in the inorganic phosphate and potassium serum concentrations and a rise in blood sugar. However, with epinephrine, there is a rise in pyruvate and lactate content of the blood, but with glucagon, there is no change or possibly a fall.

It has been shown that glucagon does not act on muscle glycogen. Ellis showed that dihydroergotamine antagonized the hyperglycemic effect of epinephrine, but not that of glucagon. If dihydroergotamine is given prior to the administration of cobaltous chloride, the hyperglycemic effect of cobalt does not occur.

This explains an observation of Goldner's who showed that there was a rise following the administration of cobaltous chloride to the depancreatized animal.

Cross circulation experiments in dogs by Foa, et al, have shown an increased output of a hyperglycemia-producing substance, presumably glucagon, from the venous blood of the pancreas under the influence of specific experimental procedures.

The problem, of course, is to determine the clinical usefulness of glucagon. We have studied the effect of glucagon on the various biological procedures used to test insulin. With the mouse convulsion test, we have noted no difference if glucagon is added. In the production of rabbit hypoglycemia, there is a transient hyperglycemia when glucagon is added, but the end-point is unchanged. These data indicate that the presence of glucagon does *not* interfere with the assay of insulin. There may also be some relationship of glucagon to growth hormone. In some animals administration of growth hormone produces a rise in glucagon.

Of course, the fundamental interest lies in the relationship to diabetes. As you all know, there are two types of diabetes, the "stable" or adult, and the "unstable" or juvenile. We can state superficially, that the stable diabetic resembles an alloxanized animal while the unstable diabetic represents a pancreatectomized animal as far as lability to ketosis, etc., are concerned. When the effect of glucagon is studied in these two types of diabetics, it is found that following the administration of glucagon to the stable diabetic, the blood sugar rises with a diabetic-type curve. There is no, or little, change in the pyruvic or lactic acid content and inorganic phosphate content of the serum. In the unstable diabetic, however, there is only a small deviation in the blood sugar while the inorganic phosphate does fall. That is, the unstable diabetic almost behaves as if he has his own insulin. We, therefore, find ourselves on the horns of a theoretical dilemma since insulin has been shown recently to be present in the blood of the stable diabetic, but not in the unstable.

Our experiments also suggest that the fall in serum inorganic phosphate is not related to the height of blood glucose since glucagon does not produce as great a rise in sugar as exogenous glucose, nevertheless, glucagon causes a greater fall of phosphate. The relationship to other endocrine glands is of interest. In normals, in patients with Cushing's disease and in diabetics, there is some increase in the 17-hydroxysteroid creatinine ratio following the administration of glucagon.

The various disease entities that perhaps should be studied in terms of glucagon are:

1. Familial infantile hypoglycemosis.
2. Von Giercke's disease of which there are four types characterized by:
   a. Glycogen with an abnormal molecular structure.
   b. Presence of abnormal (phosphorylase) enzymes.
   c. The absence of glycogen in the liver and
   d. Galactocemia.
3. Liver diseases in which the glucagon level might serve as liver function test. (The study of the manner in which liver glycogen is handled.)
4. The various clinical type of diabetes.

Dr. John B. Fuller (Assistant Professor of Pathology)

Is there any insulin in glucagon which would account for the hyperglycemic effect in the unstable diabetic?

Dr. Waife

There is probably less than 0.3% glucagon in insulin. An average dose of insulin should, therefore, contain sub-effective amounts of glucagon. As far as we can determine, there was not insulin in our preparation of glucagon used as described here. Chronic toxicity studies have shown no ill effect whatsoever from glucagon given in large daily doses for many months.

Dr. Z. Z. Godlowski (Fellow in Medicine)

Argentaffin cells are present in the stomach and jejunum. Extracts of the stomach have produced marked hyperglycemia. Extracts of the jejunum have produced slight hyperglycemia. After the administration of cobaltous chloride, no argentaffin cells are found.

Dr. Waife

Fadden reported argentaffin cells and the alpha cells of the pancreas are not the same using special histochemical stain technique.

Question (Name of inquirer not recorded)

I fail to appreciate the significance of the

failure of pyruvate to rise with glucagon.

Dr. Waife

One would expect a rise in pyruvate after the administration of glucagon. In the intermediate metabolism of glucose, the molecule splits into two 3-carbon (pyruvate) molecules. From pyruvate metabolic pathways lead to CO_2, to acetate and fat, and even back to glucose. Since glucagon produces a hyperglycemia, we expected the endogenous glucose to produce similar reactions to exogenous glucose, i.e., rise of pyruvate.

‹‹‹ ›››

Medical Library Association scholarships

The Medical Library Association is offering four scholarships of $150.00 each for summer school courses in medical library work in 1955; two at Columbia University and two at Emory University.

Applications for these scholarships should be made to the school at the time of application for enrollment. Since credentials must be approved in advance, application for admission should be made as far as possible before the date of opening of the session and sufficiently early in the year to permit the schools to pass upon the credentials and forward applications for scholarships to the Medical Library Association. Transcript of academic records should be submitted to the school even if applicant is not a candidate for a degree. April 1, 1955, is the Association's closing date for scholarship applications and candidates must already have been accepted by the school. Completion of either course will enable a student with a bachelor's degree and one year's library school training to qualify for Grade I certification by the Medical Library Association.

The course at Columbia University on the Medical Library is offered July 5 — August 12; registration, June 30 and July 1. It is a survey and evaluation of library resources in medicine, with emphasis on bibliographical and information sources. Some attention is given to special service problems in medical libraries. The course will be given by Mr. Thomas P. Fleming, Librarian, College of Physicians and Surgeons. It carries a credit value of 3 points. Tuition is $75; registration, $10. For further information write to The Dean, School of Library Service, Columbia University, New York, 27, N.Y.

Emory University offers a course in Medical Libraries July 18 — August 20. The purpose of the course is to give an introduction to medical resources and their use in medical education, medical research, and care of the patient. A major portion consists of a survey of the literature and its bibliographical control. Attention will be given to literature searching as an aid in medical investigation. Consideration will also be given to the application of library techniques, administration, and procedures to medical librarianship. The instructor for the course is Miss Mildred Jordan, Librarian of the Calhoun Medical Library, Emory University Medical School. It has a crediit value of 5 quarter hours and meets 10 hours a week. Tuition is $60; matriculation, $5. For application forms and further information write to The Director, Division of Librarianship of Emory University, Emory University, Georgia.

COOK COUNTY HOSPITAL CASE RECORDS



Retroperitoneal Cystadenoma of the Ovary

Frank J. Jirka, Jr., M.D.*, and Thomas W. Samuels, M.D., Chicago**

L. B., a 46 year old white woman entered Cook County Hospital on September 12, 1953, with the presenting complaint of feeling and acting "peculiar" for the past three days. This was described by her husband as being "out of character,". She practically ceased talking because of hiccups which were aggravated by talking.

Past history revealed hypertension for a period of eight years. Six months prior to admission she was told she had diabetes and was advised to take insulin daily. Six weeks prior to admission she began having daily episodes of vomiting following meals, associated with a twenty pound weight loss. Past history also revealed an operation for "female trouble" in 1930, the exact nature of which could not be ascertained.

Systemic review showed increased urinary frequency during past two to three years with nocturia five to six times during the past month. Last normal menstrual period had been in July 1953. Since that time the flow had been diminishing.

Physical examination showed, blood pressure 180/84, pulse 120, temperature 101.4° F. crepitant rales were heard in both lung bases. There was moderate generalized abdominal tenderness to deep palpation and bilateral costovertebral angle tenderness. Pelvic examination at this time revealed an enlarged nodular uterus with a fullness in the left adnexa.

Urinalysis showed no sugar but 2 plus albumin and 30-35 white blood cells per high power field.

The following day the left pupil was noted to be slightly larger than the right. A spinal tap revealed cloudy fluid, opening pressure 150, 2 plus pandy with closing pressure 90 and 1700 white cells per cubic millimeter. Culture of the spinal fluid showed Escherichia coli. Sensitivity studies revealed aureomycin to be the antibiotic of choice. Fasting blood sugar on 9/14/53 was 544 mgm/100 cc. Urine culture revealed Anaerogenic paracolon bacillus.

The patient gradually responded to aureomycin, gantracin, insulin, nasal oxygen, parenteral fluids, and whole blood. She was discharged on 10/22/53 with her diabetes well controlled and to be followed in the diabetic and cardiac clinics.

From the Surgical Service of Dr. Manuel E. Lichtenstein, Ward 31 and the Urological Service of Dr. William J. Baker, Cook County Hospital, Chicago, Illinois.

***Senior Resident in Urology, Cook County Hospital.**

****Senior Resident in General Surgery, Cook County Hospital.**



Figure 1. Soft Tissue Mass Outlined by Air in Retroperitoneal Space.



Figure 2. After more air had been injected into the retroperitoneal space with slight displacement of mass downward.

The patient was not seen again until she reentered Cook County Hospital on 11/10/53 complaining of chills, fever and vomiting of two days' duration with abdominal pain, dizziness and paresthesia of fingers and feet of three weeks and hiccoughing of five weeks' duration respectively.

Essential physical findings on this admission were a temperature of 103°, blood pressure 210/104, pulse 102, diabetic retinopathy and the heart slightly enlarged to the left with a systolic murmur at the apex.

Laboratory findings revealed a hemoglobin of 51% with 2.94 red blood cells and 6100 white blood cells.

Urinalysis showed 20-30 white blood cells per high power field with 4 plus albumin.

Spinal puncture was essentially negative except for 1 plus pandy. Chest plate confirmed findings of left ventricular enlargement.

Fasting blood sugars were elevated ranging from 203-264 mgm/100 cc, and patient was placed on a diabetic regime.

During her hospital stay patient developed signs of cardiac decompensation and was therefore digitalized.

Despite heavy antibiotic therapy, patient persisted in running a febrile course for about seven days. Temperature then became normal with occasional spiking, until 1/2/54, at which time she again became febrile for several days. Throughout this febrile course there was a persistence of abdominal pain. Blood cultures and agglutinations and throat cultures during this period were repeatedly negative while repeated urinalyses revealed many white blood cells with anaerogenic paracolon being cultured from multiple urine specimens.

An intravenous pyelogram was done. This demonstrated left renal pelvic dilatation with lateral displacement of the left ureter. A soft tissue mass was faintly visualized extending from the second lumbar vertebrae to the left iliac brim. Retrograde pyelography and barium studies of the upper and lower gastrointestinal tract confirmed the presence of this mass.

The patient was transferred to the urological service for further evaluation by paracoccygeal air insulflation. Figures 1 and 2. Injection of 500 cc of oxygen under local anesthesia into the paracoccygeal area with patient in the knee chest position, followed by x-ray of the abdomen,

revealed the mass to be retroperitoneal. It was of such size that it extended across the mid line. Since the mass was considered not to be urological in origin, a surgical consultation was called and an exploratory laparotomy was recommended. However, the patient refused surgery, and left the hospital on 2/10/54.

The patient was readmitted to the Medical service on 3/5/54 in rather severe cardiac decompensation. She responded quite well to digitalization, mercurials, and low salt diet. She continued to complain of pain in the right side of the abdomen and increased frequency of vomiting. The urine still showed 4 plus albumin and was loaded with white blood cells. At this point the patient consented to surgery and was transferred to the surgical service. She was given blood transfusions preoperatively, and was explored through a left paramedian incision. A large (football size) cyst containing 2000 cc of clear yellow fluid was found in the left retroperitoneal space. It was carefully dissected away from the mesentery of the sigmoid colon and the left ureter, and completely excised. It was evident that the cyst had exerted considerable pressure against both the sigmoid colon and the ureter. The sigmoid mesentery was stretched to tissue paper thinness. The ureter proximal to the cyst was dilated.

At the base of the cyst was found small 2-4 millimeter areas of yellow luteal-like tissue. Microscopic diagnosis was papillary cystadenoma of the ovary. The uterus contained multiple fibroids. The left fallopian tube and ovary could not be found. From this it was presumed that a left salpingo-oophorectomy was performed at operation twenty-four years ago and that some amount of ovarian tissue was left behind. The post operative course was uneventful except for continued treatment of her severe cardiac disability.

The patient remained free of abdominal pain post-operatively. The few occasions of vomiting in the later post-operative period was thought to be due to overdigitalization. This subsided on a more conservative digitalis regime. The patient was discharged from the hospital one month after the operation. At that time she had no abdominal pain, has an excellent appetite with no vomiting and had no pain or burning on urination. The urine was clear and negative for albumin and white blood cells.

‹‹‹ ›››

Drug samples

How do you discard your drug samples? Here is a story of what can happen, and actually did. A school girl noticed one of her male classmates in third grade passing out pills to his pals. She didn't get any, so she told the teacher. The teacher rushed to the principal, who rushed to the children, who pointed out the source (and him without a license!) . . . This juvenile dispenser has passed a trashbox in the alley behind a doctor's house. There, by chance, on top were the package of pills which the doctor had tossed into his waste basket the day before. Moral: Be careful how and what you discard. Use a large envelope or the plumbing. Side issue: The pills in this small story were anti-emetic, for the nausea of pregnancy, and the little dears probably couldn't have been made to vomit them up if they tried. *Guillermo Osler, M.D., RX, DX, and Drs. Arizona Med. May* 1954.

CASE REPORTS

Combined Treatment with N-allylnormorphine and L-arterenol in Methadone Poisoning

Peter Pulos, M.D.*; Arthur Bernstein, M.D.; Lawrence Pertman, M.D.***, Chicago**

THE availability of N-allylnormorphine for the treatment of narcotic induced respiratory depression and coma,[1] changes a previously almost hopeless therapeutic problem to one in which a relatively good chance for recovery may be anticipated. The use of L-arterenol to combat the accompanying hypotension is also of great therapeutic value.

The combined use of these agents and the response makes the following case worthy of reporting.

A 19 year old white male, H. M., of Mexican descent was admitted at 7:25 a.m., on March 7, 1953, to Cook County Hospital in coma. He had been unconscious for six hours before being brought to the hospital. A friend, with whom he had spent the previous evening, had been admitted to a nearby hospital in a similar state. No other history was obtainable.

***Resident in Medicine, Cook County Hospital, **Attending Staff Cook County Hospital; University of Illinois, College of Medicine, ***Associate Attending Staff Cook County Hospital; University of Illinois, College of Medicine.**

Examination on admission revealed a comatose young male. His respirations were slow and gasping. The blood pressure was 100/60 mm. Hg., the pulse rate was 120 per minute. The skin was moist and marked cyanosis was present. The pupils were constricted, they were equal in size and did not react to light. Examination of the chest revealed resonance to percussion; there were diffuse ronchi present throughout both lung fields. The heart was of normal size and contour, the rate was rapid and regular, there were no murmurs. The abdomen was held tensely and was scaphoid; the liver and spleen could not be palpated. The genitalia were normal. The rectal tone was poor, no masses nor hemorrhoids were present. Stool benzidine examination was negative. The extremeties were negative except presence of four needle puncture wounds along the superficial veins of the left forearm. Neurologic examination revealed bilaterally equal though hypoactive deep tendon reflexes; no pathologic reflexes were elicited.

Gastric aspiration yielded a slight amount of bloody fluid which was considered to be trau-

matic; this specimen as well as blood and urine were sent for toxicologic analysis. The blood and urine gave a precipitation of alkaloids, but failed to reveal the presence of morphine or of its derivatives. Trace amounts of barbiturates were found in the urine specimen.

Lumbar puncture was done shortly after admission. The spinal fluid was clear and colorless. There were 3 cells per cubic millimeter which were polymorphonuclear leucocytes. The pressure of the spinal fluid was 190 mm. of H_2O. The Pandy reaction gave no precipitate.

Direct laryngoscopic examination revealed no spasms of the cords; a small amount of fluid was aspirated from the trachea. Oxygen per nasal catheter was given. Caffeine sodium benzoate 0.3 Gm. was given intravenously and a flask containing one liter of 5% dextrose in water was given by intravenous route.

On the assumption that the coma was due to the use of a large amount of some unknown type of narcotic, and because of the critical appearance of the patient, 10 mg. of N-allylnormorphine was given intravenously at 11 a.m. In 28 seconds the patient responded with an increase in respiratory rate and pupillary dilatation. Twenty minutes later, the patient was sufficiently awake to respond to direct questioning; he gave his name, and age, admitted receiving a "shot" the previous night. He said that he had taken "Dolophine" but could not state the amount. Although lethargic, his condition remained fair until midnight of the day of admission, when his respirations seemed labored. N-allylnormorphine, 10 mg. was again given intravenously with immediate improvement of respiration, dilation of the pupils, and increased consciousness.

The blood pressure 3 hours following admission had dropped to 64/40 mm. Hg. At 12:40 p.m., 4 cc. of L-arterenol in one liter of 5% dextrose in water was administered by intravenous infusion and was allowed to enter the vein at approximately 30 drops per minute. At 1:20 p.m., the blood pressure was 74/50 mm. Hg. At this time the infusion of L-arterenol was stopped and the blood pressure immediately fell to 60/50 mm. Hg. The infusion of L-arterenol was restarted and the blood pressure again rose to 78/56 mm. Hg. At 5:20 p.m., 500 cc. of plasma were given intravenously. The intravenous infusion of L-arterenol was continued on March 8th., (second day) and by midnight the blood pressure had gradually risen to 110/70 mm. Hg. On March 9th., (third day), at 1:30 p.m., the infusion of L-arterenol was discontinued and the blood pressure was maintained at a level of approximately 108/60 mm. Hg. No further medication was given. The patient remained well, was alert and able to walk around the ward.

In the two cases reported by Fraser et al[2] the use of N-allylnormorphine as an antidote was recommended for Methadone Hydrochloride poisoning. Consciousness was restored and respiratory depression successfully combated with two 10 mg. doses of N-allylnormorphine in our case.

Although N-allylnormorphine may also reverse the fall in blood pressure[3] produced by narcotic drugs it did not seem to be effective in this case. The use of L-arterenol as an adjunct medication seemed indicated in view of the extremely low levels of blood pressure noted. There is no known contraindication to the combined use of these two drugs. In our case the combined use seems to have been extremely beneficial.

SUMMARY

1. A case of severe respiratory and circulatory collapse following the taking of Methadone hydrochloride intravenously is reported.
2. The response to treatment with both N-allylnormorphine and L-arterenol is noted.

BIBLIOGRAPHY

1. Smith, C. C., Lehman, E. G., and Gilfillan, J. L.: Antagonistic action on N-allylnormorphine upon the analgetic and toxic effects of morphine, methadone derivatives and Isonipecaine, Fed. Proc. 10:335-336 (March) 1951.
2. Fraser, H. F.; Wikler, A.; Eisenman, A. J.; Isbell, H.; use of N-allylnormorphine in Treatment of Methadone Poisoning. J.A.M.A. Vol. 148, No. 14, P. 1205-1207 (April 5) 1952.
3. Eckenhoff, J. E., Elder, J. D. ,and King, B. D.: The effect of N-allylnormorphine in treatment of opiate overdose, Am. J. M. Sc. 222:115 (July) 1951.

A Psoriatic Rheumatoid Arthritic: Successful Result with Massive Cortisone Therapy

A. Lieberman, M. D., Ph.D.

A VERY unusual combination of diseases responded exceedingly well to massive cortisone medication after trial with "orthodox" dosages had resulted in therapeutic failure.

After the first burst of unbridled enthusiasm in the use of cortisone had waned, many authorities swung to the other extreme. O'Leary[1] reduced indications for cortisone to: (1) self-limited hypersensitivity reactions . . . (2) serious or otherwise fatal conditions. . . ". He goes on further to state: "an occasional case of psoriasis . . . may derive temporary benefit . . . character of complications . . . contraindicate their use except under exceptional circumstances."

It is universally accepted that diabetes mellitus is a counter-indication to use of cortisone in large amounts. Also, Schizophrenia is a condition which cortisone will aggravate or even sometimes induce a previously unstable individual.

A search of both foreign and American literature failed to turn up a case similar to this one. Accordingly, he was presented at the 1/13/54 meeting of the New York Rheumatism Association.

At this same meeting, there was presented a case of acute disseminated lupus erythematosus that is being kept alive by huge cortisone dosages but which had to be given *shock therapy* because of the Schizophrenia apparently induced by the medication. (Stanley Kogut, Bellevue Hospital).

My own case report follows:

M. S. — Single, white, male born in 1912. Inducted into the Army in 1942 and discharged on October 26, 1943.

From the Veterans Administration Hospital, Northport, Long Island, New York.

Presented at the New York Rheumatism Association Clinical Conference, New York Academy of Medicine 1-13-54.

The psoriasis and rheumatoid arthritis appeared in the Spring of 1943. He became hospitalized in the Summer of 1943 and has been continually hospitalized since that time. The psoriasis and rheumatoid arthritis began simultaneously and progressed rapidly since that date. In 1947, patient began to develop mental symptoms sufficiently to attach a diagnosis of schizophrenia by the fall of that year. Diabetes began to develop at that time and continued to become progressively more severe until by 1950 he required in excess of 100 units of insulin daily. The psoriasis became extreme and refused to go into any type of remission in spite of treatment and medication.

In June 30, 1953, Dr. Currier McEwen, Area Consultant in Internal Medicine, advised maximum dosage of Cortisone possible be given with compensating doses of insulin for the diabetes. He also advised at that time to watch very carefully for symptoms of toxicity, both physical and mental. The patient had previously had Cortisone in 1950 for three weeks, in daily doses of 50 mgm., without and evidence of either improvement or harm being done as far as the psoriasis and diabetes were concerned. Of course, there was no expectation of improving the fixed deformities of the rheumatoid arthritis.

On July 15, 1953, the patient "was still actively hallucinating and had many delusional complaints". He was unable to smoke and his speech was almost unintelligible. The generalized acute psoriasis was of the most extreme form, almost the entire body was covered. On account of the crippling arthritis, the patient presented the gravest type of nursing problem. At this time, patient was receiving 175 units of insulin, both N.P.H. and regular, and the diabetes was still very difficult to control, acetone and sugar being

spilled almost every day. Following the advice of Dr. McEwen, patient had a complete laboratory, mental and physical re-evaluation.

The Cortisone was stepped up rapidly until a maximum dosage of 150 mgm. t.i.d., a total of 450 mgm. daily, was reached. This was kept up for one month and then dropped to 100 mgm. t.i.d., for one month, and then maintained (after October 6, 1953) at 75 mgm. b.i.d. until January 1, 1954 at which time 50 mgm. b.i.d. was given. The insulin had been increased correspondingly until at one time the daily dosage stood at a level of over 200 units daily.

In view of the well-known contra-indications to Cortisone, especially in the dosages as mentioned, the results of the Cortisone therapy in this case are quite striking. The insulin dosage, had gone up to 200 units daily at one time, was on January 10, 1954, only 105 units daily when he had an insulin reaction. The patient was then reduced to 60 units daily. The patient's psoriasis at the beginning of this massive course of Cortisone appeared at first to be unaffected. At the end of about six weeks however, the lesions began to pale, the skin began to clear and by the end of two months of this massive therapy, all visible signs of the psoriasis were gone. Pari passu, the patient showed remarkable mental improvement. He stopped being completely withdrawn and will now talk with the hospital personnel and maintain a reasonable degree of contact with them. He will smoke cigarettes and he reads illustrative magazines. An orthopedic consultant is of the opinion that the rheumatoid deformities are too extensive to permit reparative surgery.

On January 15, 1954, Cortisone dosage was dropped to 25 mg. daily. Three days later he had a sudden severe psoriatic flare-up. 200 mgs. of Cortisone were given in one dose orally. Within 24 hours skin cleared up *completely*. He was then put on Cortisone 25 mgs. b.i.d.

On March 15, 1954, the psoriatic lesions flared up again. The eosinopenic (Thorne) test was positive. 80 units of ACTH given i.m. daily for ten days failed to clear the lesions. 200 mgs. of Cortisone were given again as before. Response was less prompt. Three more 200 mg. doses of Cortisone were required to clear the lesions.

On June 1, 1954, the Cortisone was stopped completely. By June the 20th, there was a very severe flare-up of all lesions. Patient was regressed, markedly mental and again became dull and apathetic. Cortisone was given in the previous maximum dosage of 150 mgs. t.i.d. By July 15th, all lesions had faded. It is interesting to note that the patient's mental status was markedly influenced by the resumption of the Cortisone. He again came into contact with his environment and the improvement previously noted was fully restored. Cortisone was again tapered off until by the end of August it was stopped completely.

At this time the Thorne test was positive. We expect to give the patient intravenous ACTH the next time he lesions flare up. It will be interesting to observe whether massive ACTH dosage will be as successful as Cortisone has repeatedly been.

It is interesting to observe that since the presentation of our patient at the New York Rheumatism Association Clinical Conference, there has appeared in Sulzberger's[2] very comprehensive article the report of a case of psoriasis treated by a dosage rather similar to ours, in which massive Cortisone therapy was continued for nine months without any apparent ill effect. F. Combes[3] presents a very thoughtful article in which psoriasis is considered as a metabolic, lipid disturbance. This might form a basis for some interesting speculations of the value of massive Cortisone therapy along the line of the well-known work of Selye.

SUMMARY AND CONCLUSIONS

A very unusual combination of conditions has responded remarkably to Cortisone therapy given in amounts far beyond those usually recommended. The improvement has been maintained so far in spite of progressive dosage reductions. There have been flare-ups which were controlled by resumption of Cortisone dosages.

No valid conclusion can be drawn from this single case except to point out that: (1) It is still too early to set our minds into a rigid pattern when thinking about *how much* Cortisone to give and just *for what*. In the case presented, it took *six weeks* for "excessive" Cortisone therapy to affect the psoriasis. Then the schizophrenia and the diabetes mellitus both responded in a completely unexpected, even if very gratifying, manner. While we could speculate at length on the theory of what happens when the

patient's own adrenal functioning (or malfunctioning) is totally suppressed by over-adequate replacement of endocrine material, and while we could also expiate at similar length on just what the Cortisone might have done to the schizophrenia in this patient, it seems much better to present the undisputed sequence of events. It is hoped that this report might stimulate others to treat their cases in a similar manner. If their results will be confirmatory, further practical and theoretical studies will be in order.

BIBLIOGRAPHY

1. O'Leary, Paul A. Use and Abuse of Cortisone and Corticotropin in Dermatology. A.M.A. Journal, 8-29-53, Vol. 152, No. 18, Page 1695-1698.
2. Sulzberger, M. B. Prolonged Therapy with Cortisone for Chronic Skin Diseases. A.M.A Journal, 7-10-54, Vol. 155, No. 11, Page 954-959.
3. Combes, Frank C. Management of Psoriasis as a Metabolic Lipid Disturbance. Vol. 54, No. 13, Page 1945-1949. N. Y. S. Journal of Medicine. 7-1-54.

« « « » » »

The dumping syndrome

One of the most distressing complications of gastric resection is the development of so-called dumping syndrome. The syndrome may be defined as the occurrence in varying degrees of sweating, nausea, emesis, flushing, abdominal distention, palpitation, rapid and sudden violent peristalsis, and even fainting, appearing near the end of a meal or shortly after eating solid food and relieved by lying down. In the literature are to be found numerous and various explanations for this syndrome, and the fact that so many theories exist is evidence that not one is entirely acceptable and that we do not know the exact cause. It is our feeling that this complication is preventable by the simple expedient of instructing the patient in his eating habits, with emphasis on the amount rather than type of food. This educational program starts in the preoperative period with a detailed explanation of the nature of the operation and the necessity for small frequent feedings, and the instruction is carefully continued into the postoperative period. We feel that this program is of the utmost importance because it is usually possible to produce the classical clinical picture of dumping syndrome at will in the immediate postoperative period by permitting the patient to overdistend the gastrojejunal or gastric duodenal pouch with food. If overdistention is prevented, this distressing complication rarely is seen. The patient is told that at the end of two to three months he will be able to eat and drink anything he desires with no restriction on amount. In the postoperative period he is started on six small daily feedings and is discouraged from taking a large amount of food, particularly in the morning, and he also is instructed to take liquids, whenever possible, at a different time from solid foods. By the time the patient is discharged from the hospital, he will be on an adequate diet with no restrictions as to type of food. We are convinced from our own clinical experience that whatever the etiology of the dumping syndrome might be, if this dietary routine is carefully followed, the occurrence of dumping syndromes will be infrequent, and one of the chief objections to gastric resections in the treatment of peptic ulcer will be eliminated. *Elmer Milch, M. D. et al., Some Considerations In The Surgical Treatment Of Peptic Ulcer. New York J. Med. Aug. 1, 1954.*

EDITORIALS

Foreign medical schools

Many medical schools throughout the world are under government control. In Italy, for example, professors are recruited by open competition. Salaries are fixed by the government and clinical professors are allowed a private practice. Clinical subjects, therefore, attract the best students.

At present, there are 21 medical schools in Italy. The larger institutions are overcrowded and lack equipment. In 1950, for example, over 660 freshmen were admitted to the Rome Medical School which, at the time, had a total enrollment of 5,612.

Russia has 63 medical, four dental, and eight pharmaceutical institutes. Entrance is by competitive examination and approximately half of the 26,000 students entering the medical and pharmaceutical institutes each year are women. More than 90 per cent of the students receive a state stipend. There are 300,000 physicians in the USSR compared with 20,000 in Tsarist Russia. The Soviet physician is a public servant whose primary loyalty is to the state and not to the patient.

Sweden has three medical schools and a fourth is being started in Gothenburg. About 150 doctors are graduated each year from these institutions. Their standard of training is high and only 5 per cent of the annually registered physicians go directly into general practice. The remainder continue their training to acquire knowledge and experience in various specialties.

The annual output of all medical schools in Great Britain is about 2,100. It has been said that practically all students intend to qualify for specialist or consultant status, mainly for the higher financial awards. According to Viswanathan[1] the G.P. "is looked down upon by the specialists and naturally suffers from an inferiority complex in consequence." The general practitioner looks after the patient from start to finish whereas the specialist comes in only in a diagnostic or therapeutic capacity.

In this country, there is a growing tendency among our teaching institutions to make scientific medicine more comprehensive and to encourage a better relationship between the specialist and the G.P.

During the past decade, three new medical schools came into being — in Washington, California (Los Angeles), and Miami. One school acquired Class A rating (Chicago Medical School). During this time, two existing schools (Alabama and North Carolina) expanded into four year institutions. The University of Missouri and the West Virginia Medical Schools are planning to follow suit and two more are in the blueprint stage (Einstein and the University of Florida). In 1954, our 81 medical schools had a total enrollment of 28,400, with 7,489 in the freshman classes.

‹ ›

Andy Hall's 90th birthday

Andy Hall of Mt. Vernon celebrated his 90th birthday on Saturday, January 8 and the city of Mt. Vernon turned out to greet him on this occasion. It was recalled that a year ago on his 89th birthday, Andy slipped out and went fishing, so notice was served on him to be at home

1. R. Viswanathan N.A., M.D., M.R.C.P. (London), T.D.D. (Wales); MEDICAL EDUCATION IN CERTAIN WESTERN COUNTRIES. J. Indian Med. Assn., Nov. 16, 1954.

on January 8th so his friends and neighbors could greet him on this occasion.

The big birthday celebration was arranged by the local American Legion Post of which Andy is a charter member. Posters greeting Andy on his 90th birthday appeared in windows of all business houses and professional offices in that city of 20,000 inhabitants. All afternoon thousands of his friends, former patients and his babies greeted him at the city hall where the mayor and other city and county officials were on hand to act as the reception committee, along with Legionnaires.

The American Legion Post furnished the birthday cake, a six tier affair more than four feet high and 40 inches wide, and with an old army saber, Andy cut the cake. An orchestra was on hand as were representatives of the press from a number of metropolitan papers, radio and television attendants making platters to be released later through their respective channels. Andy's babies wore cards, the youngest two years of age and the oldest 65 years. One young miss greeting Andy was asked if she was one of his babies, and she stated that she was born away from Mt. Vernon, but her mother and grandmother received their first spanking from him.

After greeting thousands of friends and well wishers throughout the afternoon, a dinner was held at 6.00 p.m. at the Masonic Temple, but with the understanding that it must be over in time to permit Dr. Hall to be present at the evening basketball game with his favorite local high school team, last year's state champions, to play against a Chicago team. Andy attended the state tournament last year at Champaign when the Mt. Vernon team won the championship, and he is the number one rooter at all local games. Roland R. Cross, Director, Illinois Department of Public Health was the speaker at the banquet. For four years Dr. Hall acted as Director of this State Department, and was responsible for the enactment of several laws which have aided materially in reducing the morbidity and mortality rates in this state. In 1949 he was selected as the physician of the year by the American Medical Association and during his year, he travelled by air all over the country to attend meetings to which he was invited.

Some 32 years ago he was elected as Councilor for the Southern Illinois District which at that time comprised some 26 counties. After several years as Councilor of the old 9th district, he recommended that two districts be created in Southern Illinois which was done by the House of Delegates at the Annual Meeting.

When the Fifty Year Club was organized some 17 years ago he was selected as Chairman of the Fifty Year Club Committee, and has remained as its chairman to this time. Fifteen years ago he became a member of this club and has personally presented certificates and emblems to many of the more than 1,000 Illinois physicians who have been so honored during this period of time.

The official representatives of the Illinois State Medical Society at this 90th birthday celebration, were Drs. Arkell M. Vaughn, president and Harold M. Camp, Secretary. The Society presented Dr. Hall with a modern spinning rod and reel which he has promised to use on his 1955 fishing trips to his favorite lake in Kentucky. He also is a hunter, still bringing in the limit of ducks, quail and pheasants. When asked to what he ascribes his unusually good health at the attained age, he says first of all, through selecting the right ancestors, living right, having hobbies and taking vacations.

All physicians in Illinois know and honor Andy Hall, and many thousands from the other 47 states know him and his outstanding work. All unite on this occasion to send greetings and best wishes to this grand man of Medicine.

‹ ›

Committee On Industrial Health resolution

As a part of the Illinois State Medical Society's program to improve medical relations and elevate the standards of medical care and administration in workmen's compensation cases, the Committee on Industrial Health has in executive session on November 22, 1954 unanimously approved the following resolution:

"WHEREAS, the Committee on Industrial Health has been authorized and directed by the Council of the Illinois State Medical Society to investigate and report to the State Society and its appropriate component any questionable or unethical act or misconduct by a member of the medical society in connection with a workmen's compensation case, and to make available by publication in appropriate medical siciety

bulletins and by letter to the Industrial Commission and representatives of labor, industry and the legal profession, the procedures for submission of complaints on medical services and fees in workmen's compensation cases to the Committee on Industrial Health, therefore be it

"RESOLVED, that the Chairman of the Committee on Industrial Health address a letter to all above named organizations stating that James H. Hutton, Joseph F. O'Malley, F. Lee Stone, and Myron J. Tremaine, committee members, are directed by and authorized on behalf of the Committee on Industrial Health: a) to receive all formal written complaints giving specific details; to refer said complaints to proper committees of local medical societies and to determine the disposition of such complaints; and b) to receive informal complaints and communications; to take appropriate action on said complaints and communications, including, if warranted, the preparation and submission of formal written complaints, giving specific details, to proper committees of local medical societies and to determine the disposition of such complaints."

‹ ›

David John Davis 1875-1954

Dr. David J. Davis has passed away from us, and it is fitting that we record our appreciation of his life and work.

His parents immigrated from north Wales and settled near Racine, Wisconsin, in 1848. His boyhood and youth were spent on a farm where he learned some of the fundamentals of biology, which were of value to him in later years. The important thing was that in his secondary school years he acquired, through the suggestion and encouragement of two of his teachers, an ambition to go to the University of Wisconsin.

In his freshman year (1894-1895) he made his decision to follow a career in medical research. This was due to the influence of his room-mate, an upper classman doing research in American History, and of a group of outstanding scientists under whom he studied.

Included in the faculty were Professor H. L. Russell and W. D. Frost, in Bacteriology. The former had just returned from Europe and had brought with him some of Koch's old tuberculin. Davis obtained some of this and in his winter vacation (1896-1897) he tested for tuberculosis the herd of cattle (about 30 head) on the old farm. About one-third of them reacted positively to the test and were disposed of. This was the first of such tests in that part of Wisconsin, and among the first in the U. S. Davis had had his start in research.

He finished his university studies and obtained a B. S. degree and a Phi Beta Kappa key in 1898.

After teaching sciences in the Berlin (Wisconsin) High School two years, Davis entered Rush Medical College. The two years of preclinical sciences was then offered, at the University of Chicago, to Rush students for the first time; then two years of clinical studies on the "West Side", and a degree of M.D. December 18, 1903. Except for an internship (1906-1907) at the Presbyterian Hospital under Dr. Frank Billings, the next few years were spent in research at the Memorial Institute for Infectious Diseases. On the basis of studies in the bacteriology of whooping cough, Dr. Davis received the degree of Ph.D. Magna Cum Laude from the University of Chicago (1905).

Negri bodies in the cerebral tissues of humans and animals were demonstrated by him for the first time in Chicago, and perhaps in the country.

Typical organisms of sporotrichosis were cultured from the skin lesions of a patient, and this led to studies of fungus infections in the human.

Probably Dr. Davis's most important work was with streptococci.

(1) Hemolytic streptococci were found in the bottom of tonsil crypts and periapical abscesses of teeth. When cultures of these were injected intravenously into rabbits, there was experimentally produced for the first time a non-suppurative form of arthritis. Davis demonstrated this for Professor Aschoff when studying in Freiburg in/B (1910).

(2) Of utmost importance was an investigation of an epidemic septic sore throat which swept over a part of Chicago in 1911, attacking thousands of individuals and causing some 500 deaths. Dr. J. A. Capps joined Davis in the work. It was found that 85% of the victims were drinking milk from one dairy; that the pasteurizing plant was in bad condition and

often out of use; that milk taken from cows with mastitis contained hemolytic streptococci identical with those found in patients' throat cultures. With a quarantine of the cows, this epidemic soon abated, and after the Health Department established a rigid control of all pasteurizing plants there has been no recurrence of the epidemic. Dr. Davis determined that the organism was of a type distinct from the ordinary streptococcus and it has been known as the streptococcus epidemicus of Davis. He was the first to show that the specific mastitis in a healthy cow could be produced by milking with hands smeared with the streptococcus from cultures, therefore the udders of the cows can be infected by carriers.

There were also some studies proving that the B. Influenza (Pfeiffer) is *not* the cause of influenza.

In all, his publications number well over 100. Included among his papers are a number on medical history, in which he was much interested as a source of medical knowledge. A memorial lectureship in medical history has been established at the University of Illinois Medical School. He was permanent historian of the Illinois State Medical Society.

In 1910, Dr. Davis studied abroad in Vienna and Freiburg in/B. Upon his return (1911) he was pathologist at St. Luke's Hospital, and in 1913 became Chairman of the Department of Pathology and Bacteriology at the University of Illinois Medical School. In 1924, he became Dean of the School, and held both of these positions until his retirement in 1943. The University was fortunate in having his wise counsel and leadership during the period of reorganization and great growth of the Medical School, and the enormous building program for the three professional schools.

Dr. Davis was a member of numerous professional societies and commissions.

Dr. Davis' greatest pleasure and satisfaction was in his family. In 1908, he married Myra Helen Jones, of Toronto, who was a supervisor of nurses at the Presbyterian Hospital, Chicago. There are two sons: Dorland Jones Davis, of Bethesda, Maryland, now in the U. S. Public Health Service, and David Edward Davis, now Associate Professor of Ecology in the Johns Hopkins School of Hygiene and Public Health. Dr. Davis was a devoted husband and a kind and inspiring father.

He was a scientist, an educator and a scholar, and a contributor to the welfare of mankind. He loved life and was fond of music, especially the grand old anthems and hymns, and enjoyed being in the out-of-doors and in the mountains.

‹ ›

History of Medical Practice in Illinois

The Second volume of The History of Medical Practice in Illinois is now on the press. This volume relates in much detail, the history of medical practice in Illinois from 1850 to 1900. Following the introductional foreword, there will be 21 chapters in the book each prepared by as many authors. There will be approximately 650 pages in this volume, and very few illustrations.

It is hoped that the completed book will be ready for distribution by April 1, and advance orders are now being received.

Medical history in Illinois is an important and interesting subject, and many advancements in all branches of medicine and surgery have originated in this state. For a number of years, there were literally dozens of medical schools in the state, while today there are five. Early medical schools were located at St. Charles, Jacksonville, Quincy, Rock Island and several other cities outside of Cook County.

Even before Illinois became a state of the Union, under the old Territorial Act it was mandatory that medical societies be organized and there was a penalty for the physician who failed to attend the meetings without a legitimate excuse. The development of specialties in the state are well described in this volume and every physician and many others will be interested in many things that are brought out in the book.

Every county medical society is to be asked to select a committee on history and one that will be willing to aid in the sale of this second volume. The Woman's Auxiliary likewise will assist in the sale of the book and do everything possible to get the widest possible circulation for it.

All advance orders for the book which will cost $10.00, should be sent to the Secretary, Illinois State Medical Society, P.O. Drawer 156, Monmouth, Illinois.

MEDICAL ECONOMICS



John R. Wolff, Chairman, Walter C. Bornemeier, Edward W. Cannady, Roland R. Cross, Jr., E. F. Dietrich, W. W. Fullerton, Edwin F. Hirsch, Frederic T. Jung, W. R. Malony, Caesar Portes, William Requarth, Frederick W. Slobe.

Is Our Workmen's Compensation System Satisfactory?

FREDERICK W. SLOBE, M.D., CHICAGO

IN finding answers to this important question it is necessary to review the objectives of the Workmen's Compensation system because, if these objectives are not being realized, changes are obviously needed.

Also, in answering this question, although we as physicians are chiefly involved with the medical aspects of Workmen's Compensation, the medical profession has a community responsibility in calling attention to defects in the present system. Perhaps the profession is in the best position to assume leadership and be the least influenced by subjective considerations. To this end, the Committee on Industrial Health of the Illinois State Medical Society and the Council on Industrial Health of the American Medical Association have been actively engaged in a study of this important problem.

The over-all objective in Workmen's Compensation, from the medical standpoint, is the restoration of the individual, as nearly as possible, to the productive effectiveness which he exhibited before the occupational injury or illness. That is why some prefer the term "Workmen's Restoration" rather than "Workmen's Compensation."

Chairman, Committee on Industrial Health, Illinois State Medical Society.

The first essential, of course, in attaining this objective is good medical care. The method of furnishing such care varies in different states. In some states, including Illinois, the employer has the right and in others the employer or insurance carrier have the right to select the physician. In some states the employee has the right to select his own physician with usually some limitations or conditions. In still other states the employee may select his physician from a panel established by the state medical society. In highly industrialized areas the bulk of the care is usually handled by physicians specializing in industrial medicine and traumatic surgery. Such specialization usually includes availability for day and night emergencies, submission of prompt and accurate reports to the insurance carrier and employer, and an understanding of medicolegal implications. If a medical society panel is to be utilized it would seem that the panel should be restricted to physicians who have the facilities and training to furnish such service and would exclude specialists in unrelated fields, examples being obstetrics, pediatrics, and pathology. There would have to be certain safeguards, for example , to avoid changing physicians for unwarranted reasons in the midst of care. Because of third party and other

relationships peculiar to workmen's compensation, unlimited "free choice" in itself is no panacea.

Experience in some states indicates that the existence of a panel does not necessarily spread the care to most of the physicians in the community. The tendency remains for the bulk of the care to be furnished by physicians organized to give prompt, efficient service. The availability and utilization of indicated consultation service, likewise, has an important bearing on the question of good medical care, perhaps requiring that there be some centralized medical authority to insure that this be carried out.

All members of the Illinois State Medical Society have recently received a questionnaire asking about their interest in and availability for handling Workmen's Compensation cases. This is merely a survey authorized by the Council of the State Medical Society to obtain the sentiment of the profession. No change in the present system is imminent, of course, since a change in the law would first be required. Although some changes are possible without modifying the law, no such implication is warranted just because this survey was made.

Unfortunately, most compensation laws do not use the word "rehabilitation," nor specify that medical care includes rehabilitation to the extent that the injured person can carry on his old activity or engage in some reasonably satisfactory substitute. That is, there is no insistence that maximum physical and mental restoration be obtained. There is urgent need, then, for an amendment to the law to enable this to be carried out. Rehabilitation should go along concurrently with treatment and be an integral part of it. No one, especially a physician, likes compulsion, but the law itself compels the employer to meet certain obligations so it would appear that the entire community, including the medical profession, should make certain adjustments and, if need be, sacrifices in order to meet the important obligation of rehabilitating the worker. However, the mere existence of rehabilitation facilities alone will not solve the problem unless they are utilized during the period of treatment and not merely afterward when so often it is too late.

This will not apply to the average case but has reference to injuries in which there is a prolonged period of treatment or there is likely to be appreciable permanent functional impairment. Also, in such instances, there is likely to be some settlement including probable litigation. There is need for some mechanism established by law so that these employees get the rehabilitation they need.

It is a responsibility of the profession to be squarely behind such a procedure and to be cooperative in referring such patients for rehabilitation unless they have adequate facilities themselves. Such facilities are rarely available in the average physician's office.

The medicolegal implications of rehabilitation need close scrutiny when a settlement and litigation are in the offing. The injured person suffers a considerable emotional handicap in the face of his efforts to aid in rehabilitating himself, especially when perhaps an attorney wittingly or unwittingly directs his attention more toward the monetary settlement than toward his recovery. There is need for a mechanism to prevent such unfortunate occurrences. Recovery from the emotional impact of litigation and the frequent delay involved, plus the loss of the all important early weeks of active effort towards rehabilitation are often more harmful than the original injury. Lump sum settlements are likewise deplored because they are so frequently dissipated in a short period of time leaving the worker with a serious impairment and no funds. His case is closed and referral to a rehabilitation center is a rarity.

Much depends, too, upon the caliber of the Industrial Commission, the Board members and the administrative staff. These positions should be filled by dedicated career people with adequate salaries to attract those with competence. Appointive positions in higher echelons should be made on the basis of competence without regard to political affiliation. Such individuals should develop such a standing in the community that they should be immune from loss of position because of change in administration. Those in the administrative staff should have a tenure based on competence and ability with immunity from political considerations. Likewise, an educational program for those in the administrative staff should be instituted. The Commission should have access to impartial medical opinion. Conflicting expert testimony may leave the arbitrators quite bewildered.

Avoidance of the need for litigation was one of the original purposes of workmen's compen-

sation but this has not been attained. Instead, litigation runs rampart in many states with resultant administrative delay.

Money payments to the employee are not entirely germane to this discussion but they are important. It is assumed, therefore, that the scale of payments be adequate and realistic in proportion to the cost of living and the protection of the employee and his dependents. This should apply as regards both the amount and duration of payments for lost time, functional impairment and specific loss. Money payments, of course, should be adequate but how much money can replace a preventable loss of function which causes inability for the worker to engage in his former occupation? And how valuable is routine medical care if it fails to include adequate measures of rehabilitation so that the worker is unable to continue his job?

Labor interests on the one hand, and employer groups on the other are inclined to bargain about controversial matters and finally reach an agreement. The point of discussion usually centers about money and thus loses sight of the other objectives. The result is an "agreed bill" to be submitted to the legislature. This has not remedied the defects just enumerated. Nor is the legal profession in a position to take the lead. Although really a community responsibility, if the community, as such, does not assume leadership, the medical profession should consider it a duty and an obligation to do so.

Abuses in medical testimony exist. The medical profession has the mechanisms through its Grievance Committees and Committees on Medical Testimony to take appropriate action when complaints are made. The Committee on Industrial Health of the Illinois State Medical Society stands ready to act as a liaison in receiving and referring such complaints to the proper source. This has been authorized by the Council of the State Medical Society. Physicians who deliberately compromise the truth in their testimony are very few in number but they discredit the entire profession. Action can and will be taken to correct this. But for every dishonest physician there is a dishonest lawyer in collusion. So, similar action by the Bar Association is needed.

The Committee on Industrial Health of the Illinois State Medical Society also stands ready to receive complaints from physicians in their dealings with employers and insurance companies.

There are many problems to be worked out and the pressure of public opinion may be the chief source of strength in order to attain our objectives. Meanwhile, through the aegis of the medical profession all interested groups, it is hoped, will work in concert to attain the ultimate objective — the restoration of the worker to his maximum functional capacity.

‹‹‹ ›››

The freshman medic

I purchased my bones at a room full of limbs
From that deceased-looking chap called Earnest Sims.
He told of the Profs. he had taught in his day.
Of admirers in France and throughout the U.S.A,
How he'd invented that grand body pickle
Which kept dead people so fresh and so fickle.
If the Lord gave them breath tomorrow he'd wager,
They would get up and dance like any teen-ager.
We soon met his bodies and neatly dissected,
Just as Le Gros Clark in his textbook directed.
The Median Nerve coursing down through the arm,
To supply thenar muscles and skin on the palm.
The flexors of shoulder, the extensors of wrist,
The tendons which move on clenching the fist.
The arteries round elbow anastomosing,
And all this to learn—it was most indisposing.
Alan Denham, Second M. B. & All That. Queen's Med. Mag. Summer, 1954.

CORRESPONDENCE

Annual Clinical Conference

The Chicago Medical Society has announced the program for the Annual Clinical Conference to be held at the Palmer House on March 1,2,3 and 4. There is no registration fee for members of the Chicago Medical Society; for others, the fee is $5.00.

In addition to the program which follows there will be daily teaching demonstrations.

TUESDAY, MARCH 1

8:30 a.m. "Management of Coronary Occlusion" Dr. George E. Burch, Professor and Chairman, Department of Medicine, Tulane University of Louisiana School of Medicine, New Orleans, Louisiana.

9:00 a.m. "Therapy of Common Blood Disorders" Dr. Louis R. Limarzi, Associate Professor of Medicine, Department of Medicine, University of Illinois College of Medicine; Hematologist, Research and Educational Hospitals, Chicago, Illinois.

9:30 a.m. "Early Recognition of Intracranial Tumors" Dr. Winchell McK. Craig, Professor of Neurological Surgery, Mayo Foundation Graduate School, University of Minnesota; Head, Section on Neuro-Surgery, Mayo Clinic, Rochester, Minnesota.

11:00 a.m. "Immunization of Infants and Children" Dr. Franklin H. Top, Professor and Head, Department of Hygiene and Preventive Medicine, State University of Iowa College of Medicine, Iowa City, Iowa.

11:30 a.m. "The Management of Hypertensive Disease" Dr. Peter J. Talso, Assistant Professor of Medicine, Stritch School of Medicine of Loyola University, Chicago, Illinois.

1:30-2:30 p.m. Color Television—"Current Ideas in the Management of Fractures of the Upper Extremities" Dr. Edward L. Compere, Professor and Chairman, Department of Bone and Joint Surgery, Northwestern University Medical School; Senior Attending Orthopedist, Chairman, Department of Orthopedics, Chicago Wesley Memorial Hospital.

2:30-3:00 p.m. Color Television—"What May be Learned by Careful Examination of the Newborn" Dr. John L. Reichert, Assistant Professor of Pediatrics, Northwestern University Medical School; Senior Attending Pediatrician, Chairman, Department of Pediatrics, Chicago Wesley Memorial Hospital. Dr. James A. Conner, Associate in Pediatrics, Northwestern University Medical School; Senior Attending Pediatrician, Chicago Wesley Memorial Hospital.

4:00 p.m. "Diagnosis and Management of Common Shoulder Injuries" Dr Harrison L. McLaughlin, Professor of Clinical Orthopedic Surgery, Columbia University College of Physicians and Surgeons, New York, New York.

4:30-5:30 p.m. Clinicopathologic Conference

WEDNESDAY, MARCH 2

8:30 a.m. "Stress Hormones and Peptic Ulcer" Dr. Seymour J. Gray, Assistant Professor of Medicine, Harvard Medical School, Boston, Massachusetts.

9:00 a.m. "Medical Management of Peptic Ulcer" Dr. Arthur A. Kirchner, 1st Vice-President, American College of Gastroenterology; Senior Consultant in Gastroenterology to the Queen of Angels and Methodist Hospitals, Santa Rita Clinic and the Methodist Hospital Clinic, Los Angeles, California.

9:30 a.m. "Diseases of the Orbit Associated with Systemic Disease" Dr. F. Bruce Fralick, Professor and Chairman, Department of Ophthalmology, University of Michigan Medical School, Ann Arbor, Michigan.

11:00 a.m. "Cystic Ovary" Dr. John R. Schenken, Professor of Pathology and Bacteriology, University of Nebraska College of Medicine; Director of Laboratories, Nebraska Methodist Hospital, Omaha, Nebraska.

11:30 a.m. "The Identification of Carcinoma of the Lung by X-Ray Examination" Dr. Leo G. Rigler, Professor and Chief, Department of Radiology, University of Minnesota School of Medicine; Chief, Department of Radiology, Minneapolis General Hospital, Minneapolis, Minnesota.

1:30-2:00 p.m. Color Television—"The Management of Carcinoma of the Prostate" Dr. Vincent J.

O'Conor, Professor and Chairman, Department of Urology, Northwestern University Medical School; Senior Attending Urologic Surgeon, Chairman, Department of Urology, Chicago Wesley Memorial Hospital. Dr J. Kenneth Sokol, Associate in Urology, Northwestern University Medical School; Senior Attending Urologic Surgeon, Chicago Wesley Memorial Hospital. Dr. George J. Bulkley, Associate in Urology, Northwestern University Medical School; Assistant Attending Urologic Surgeon, Chicago Wesley Memorial Hospital.

2:00-3:00 p.m. Color Television—"The Acute Abdomen —Roentgen Aids to Management" Dr. Abram H. Cannon, Associate in Radiology, Northwestern University Medical School; Senior Attending Radiologist, Chairman, Department of Roentgenology, Chicago Wesley Memorial Hospital. Dr. Patrick Riley, Associate in Radiology, Northwestern University Medical School; Senior Attending Radiologist, Chicago Wesley Memorial Hospital.

4:00 p.m. "The Management of Highway Accidents" Dr. George J. Curry, Chief, Section for the Surgery of Trauma, Hurley Hospital; Member, Board of Governors, Chairman, Sub-Committee on Transportation of the Injured, American College of Surgeons, Flint, Michigan.

4:30 p.m. "Diagnostic and Therapeutic Blocks" Dr. John S. Lundy, Professor of Anesthesiology, Mayo Foundation Graduate School, University of Minnesota; Senior Consultant, Section of Anesthesiology, Mayo Clinic, Rochester, Minnesota.

THURSDAY, MARCH 3

8:30 a.m. "Management of Recurrent Carcinoma of the Breast" Dr. Frank E. Adair, Associate Professor of Surgery, Cornell University Medical College; Attending Surgeon and Executive Officer, Memorial Hospital for the Treatment of Cancer and Allied Diseases, New York, New York.

9:00 a.m. "Diabetic Emergencies" Dr. Howard F. Root, Associate in Medicine, Harvard Medical School; Director of the Joslin Clinic, Deaconess Hospital, Boston, Massachusetts.

9:30 a.m. "Conservative Management of the Diabetic Foot" Dr. Angus D. McLachlin, Professor of Surgery, University of Western Ontario, Faculty of Medicine, London, Ontario.

11:00 a.m. "A Clinicopathological Study of 1,000 Testicular Tumors" Dr. Frank J. Dixon, Professor and Chairman, Department of Pathology, University of Pittsburgh School of Medicine, Pittsburgh, Pennsylvania.

11:30 a.m. "Resuscitation of the Newborn Infant" Dr. Wyman C. C. Cole, Chief, Department of Pediatrics, Woman's Hospital, Senior Physician, Harper Hospital, Detroit, Michigan.

1:30-2:00 p.m. Color Television—"Surgery for Otosclerosis" Dr. George E. Shambaugh, Jr., Professor and Chairman, Department of Otolaryngology, Northwestern University Medical School; Senior Attending Otolaryngologist, Chairman, Department of Otolaryngology, Chicago Wesley Memorial Hospital. Dr. Eugene L. Derlacki, Associate in Otolaryngology, Northwestern University Medical School; Senior Attending Otolaryngologist, Chicago Wesley Memorial Hospital.

2:00-2:30 p.m. Color Television—"Office Proctology" Dr. Durand Smith, Associate in Surgery, Northwestern University Medical School; Senior Attending Surgeon, Chicago Wesley Memorial Hospital.

2:30-3:00 p.m. Color Television—"The Recognition of Cardiac Disorders Possibly Amenable to Surgery" Dr. Walter S. Priest, Associate Professor of Medicine, Northwestern University Medical School; Senior Attending Internist, Chicago Wesley Memorial Hospital. Dr. Paul Kezdi, Fellow in Medicine, Northwestern University Medical School; Assistant Attending Internist, Chicago Wesley Memorial Hospital. Dr. Robert R. J. Hilker, Fellow in Medicine, Northwestern University Medical School.

4:00 p.m. "The Practitioner's Role in the Diagnosis and Management of Ear Disease" Dr. Frances L. Lederer, Professor and Head, Department of Otolaryngology, University of Illinois College of Medicine, Chicago, Illinois.

4:30-5:30 p.m. Panel Discussion "Analgesia and Anesthesia"

FRIDAY, MARCH 4

8:30 a.m. "Diagnosis and Treatment of Postmenopausal Bleeding" Dr. William J. Dieckmann, Mary Campbau Ryerson Professor, Department of Obstetrics and Gynecology, University of Chicago School of Medicine; Chicago Lying-In Hospital, Chicago, Illinois.

9:00 a.m. "The Differential Diagnosis of Jaundice" Dr. Walter G. Maddock, Professor of Surgery, Northwestern University Medical School, Chicago, Illinois.

9:30 a.m. "Current Management of Pulmonary Tuberculosis" Dr. R. A. Goodwin, Jr., Chief, Tuberculosis Service, Veterans Administration Hospital, Nashville, Tennessee.

11:00 a.m. "Newer Concepts in Genito-Tuberculosis" Dr. John K. Lattimer, Assistant Clinical Professor of Urology, Columbia University College of Physicians and Surgeons, New York, New York.

11:30 a.m. "Iron Metabolism and the Anemias of Pregnancy" Dr. John L. McKelvey, Head, Department of Obstetrics and Gynecology, University of Minnesota, The Medical School, Minneapolis, Minnesota.

1:30-2:00 p.m. Color Television—"Extremity Amputations and the Modern Prosthesis" Dr. Clinton L. Compere, Assistant Professor of Bone and Joint Surgery, Northwestern University Medical School; Senior Attending Orthopedist, Chicago Wesley Memorial Hospital. Dr. Robert

G. Thompson, Clinical Assistant in Bone and Joint Surgery, Northwestern University Medical School; Assistant Attending Orthopedist, Chicago Wesley Memorial Hospital.

2:00-2:30 p.m. Color Television—"Management of Urinary Tract Infection" Dr. Paul S. Rhoads, Professor of Medicine, Northwestern University Medical School; Senior Attending Internist, Chairman, Department of Medicine, Chicago Wesley Memorial Hospital. Dr. Vincent J. O'Conor, Professor and Chairman, Department of Urology, Northwestern University Medical School; Senior Attending Urologic Surgeon, Chairman, Department of Urology, Chicago Wesley Memorial Hospital.

2:30-3:00 p.m. Color Television—"The Importance of Maintaining an Unobstructed Airway during Anesthesia and in the Unconscious Patient—Indications for Tracheostomy" Dr. Mary Karp, Assistant Professor of Surgery, Northwestern University Medical School; Senior Attending, Chairman, Department of Anesthesia, Chicago Wesley Memorial Hospital.

3:30-4:30 p.m. Panel Discussion "Antibiotics"

‹ ›

Invitation to physicians' wives

The Woman's Auxiliary to the Chicago Medical Society extends an invitation to all doctor's wives to attend the Chicago Medical Society Clinical Conference with their husbands on March 1, 2, 3 and 4.

Many activities are being planned for your enjoyment by the Clinical Conference Women's Committee. Make our Hospitality Room your headquarters and enjoy a cup of coffee with your friends. Tickets will be available for TV and Radio shows. Plan to be our guest for Tea on Wednesday, March 2nd, and don't miss the banquet on Wednesday night. Our big day will be Thursday, March 3rd, when Marshall Field & Co., will present a Style Show for us in the Narcissus Room at Field's store. The Door Prizes are fabulous; you won't want to miss it so make your reservations early with the Ticket Chairman, Mrs. L. J. Houda, 7811 Greenfield, River Forest, Ill.

‹ ›

Clinics for crippled children listed for March

Twenty four clinics for Illinois' physically handicapped children have been scheduled for March by the University of Illinois Division of Services for Crippled Children. The Division will count 17 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examinations along with medical social and nursing services. There will be 5 special clinics for children with rheumatic fever and 2 for cerebral palsied children.

Clinics are held by the Division in cooperation with local medical and health organizations, both public and private. Clinicians are selected among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or may want to receive consultative services.

The March clinics are:

March 1 — Centralia, Recreation Center

March 2 — Rock Island (Cerebral Palsy), Foss Home, 3808-8th Avenue

March 2 — Hinsdale, Hinsdale Sanitarium

March 3 — Sterling, Field House

March 8 — Peoria, Children's Hospital

March 8 — East St. Louis, St. Mary's Hospital

March 9 — Joliet, Will County T.B. Sanitarium

March 10 — Springfield, St. John's Hospital

March 10 — Alton (General and Rheumatic Fever), Alton Memorial Hospital

March 10 — Elmhurst (Rheumatic Fever), Memorial Hospital of DuPage County

March 11 — Chicago Heights (Rheumatic Fever), St. James Hospital

March 16 — Metropolis, Presbyterian Parish House

March 16 — Evergreen Park, Little Company of Mary Hospital

March 16 — Jacksonville, Passavant Hospital

March 17 — Rockford, St. Anthony's Hospital

March 17 — Sparta, Community Consolidated School

March 18 — Evanston, St Francis Hospital

March 22 — Peoria, Children's Hospital

March 22 — Effingham (Rheumatic Fever), St. Anthony's Hospital

March 23 — Springfield (Cerebral Palsy), Memorial Hospital

March 23 — Aurora, Copley Memorial Hospital

March 24 — Bloomington, St. Joseph's Hospital

March 25 — Chicago Heights (Rheumatic

Fever), St James Hospital

March 29 — Shelbyville, First Methodist Church

‹ ›

1955 college essay award contest

The Council on Undergraduate Medical Education of the American College of Chest Physicians offers three cash awards to be given annually for the best contribution, prepared by any undergraduate medical student studying for a degree in medicine, on any phase of the diagnosis and treatment of chest diseases (heart and/or lungs).

The first prize will consist of a cash award of $250. Second prize will be $100 and third prize, $50. The three winners will also receive a certificate of merit.

The winning contributions will be selected by a committee of well-known chest specialists and will be announced at the 21st Annual Meeting of the American College of Chest Physicians, to be held in Atlantic City, New Jersey, June 2-5, 1955. All manuscripts become the property of the American College of Chest Physicians.

Applicants are requested to study the format of DISEASES OF THE CHEST as to length, form, and arrangement of illustrations to guide them in the preparation of the manuscript. The following conditions must be observed:

1. Five copies of the manuscript typewritten in English (double spaced) should be submitted to the Executive Director, American College of Chest Physicians, 112 East Chestnut Street, Chicago 11, Illinois, U.S.A., not later than April 10, 1955.
2. The only means of identification of the author shall be a motto or other device on the title page and a sealed envelope bearing the same motto on the outside enclosing the name and address of the author.
3. A letter from the Dean or Chairman of the Department of Medicine of the medical school certifying that the author is a medical student studying for his degree in medicine.

‹ ›

Illinois Tuberculosis association notes

Grants for tuberculosis research recently were made available by the Illinois Tuberculosis association under a newly established program designed to stimulate medical research in this field in Illinois.

Applications submitted prior to the January 15 deadline soon will be reviewed by the research committee, which is serving as a screening group in considering and recommending approval of grants.

The next deadline for applications for grants has been set for June 1, 1955. They should be submitted to Robert H. Ebert, M.D., research committee chairman, Illinois Tuberculosis Association, 730 South Sixth Street, Springfield, Illinois.

Appointed by Dr. J. A. Stocker, Illinois Tuberculosis association president, the committee included: Dr. Ebert, department of medicine; W. E. Adams, M.D., department of surgery; George Leroy, M.D., division of biological sciences and department of medicine; William R. Barclay, department of medicine, all of the University of Chicago; Guy Youmans, M.D., department of bacteriology, Northwestern university; Karl Pfeutze, M.D., University of Illinois school of medicine and medical director of the Chicago State Tuberculosis sanatorium and Robert Johnson, M.D., University of Illinois department of physiology. Dr. Stocker, who also is assistant medical director of St. John's sanatorium, Springfield, and Ben D. Kiningham, Jr., executive director of the Illinois Tuberculosis association, are ex-officio members.

Prospective projects should be connected with tuberculosis. Preference in awarding grants will be given to qualified schools and institutions in Illinois which are equipped with adequate facilities. The size and number of grants will be determined by the research committee.

Applications for grants must include the following: general statement of the problem; name of the principal investigator and a biographical sketch with complete list of publications; description of facilities where research will be conducted and the amount of money requested.

Additional information as well as a list of research projects currently being sponsored by the National Tuberculosis association and the American Trudeau society, may be obtained from Ben D. Kiningham, Jr., executive director, Illinois Tuberculosis association, 730 South Sixth Street, Springfield, Illinois.

NEWS of the STATE



ADAMS

Society News.—At a meeting of the Adams County Medical Society in Quincy, January 12, Dr. Milton H. Kronenberg, Peoria, spoke on "Handling Industrial Cases."

New Officers.—Dr. E. N. DuPuy, secretary of the Adams County Medical Society, was named president-elect of the society at its recent meeting. Dr. Theodore L. Stebbins was installed as president. Vice presidents are Drs. E. H. Keys, Jr., and C. A. Hendricks, and Dr. Harold Swanberg is treasurer. Other officers are Drs. W. M. Libmann, accounting officer; H. M. Shair, editor and historian; P. T. Lambertus, medico-legal advisor; W. M. Whitaker, delegate to the Illinois State Medical Society; R. McReynolds, alternate delegate; councilor for three years, and G. L. Tourney, censor for three years.

CLINTON

Secretary Directs Question to Councilor.—In reporting that the Clinton County Medical Society had averaged 71 percent attendance of all its members for its ten meetings this past year, Dr. J. Q. Roane, Secretary of the society, commented that he hoped the councilor of the Seventh District would let him know how this compared with other societies in the district. A film from the American Cancer Society was a feature of the January 12 meeting of the local society.

COOK

Appointments to Illinois Faculty.—Recent appointments to the University of Illinois College of Medicine include the following: Edna Anderson, assistant professor of nursing; Abraham S. Markowitz, assistant professor of bacteriology and pathology; Edmund W. J. DeMaar, assistant professor of pharmacology; Frank E. Trobaugh, assistant professor of medicine (Rush), and Alfred Flarnheim, David A. Hamburg, and William A. Murray, clinical assistant professors of psychiatry.

New Director of School Health Service.—Dr. Buford Hall was recently named director of the health service for the Chicago Professional Colleges of the University of Illinois and assistant professor of medicine and preventive medicine at the medical school. Formerly in private practice in Lexington, Ky., Dr. Hall more recently has been serving as resident and instructor in medicine at Research and Educational Hospitals.

LeRoy Sloan Heads Institute of Medicine.—Dr. LeRoy H. Sloan was recently elected president of the Institute of Medicine of Chicago; other officers are Drs. Robert W. Keeton, vice president; George H. Coleman, secretary; E. Lee Strohl, treasurer, and Henry T. Ricketts, chairman of the board.

Staff Election.—Dr. George H. Irwin, 1304 Birchwood, Chicago, was elected president of the St. Francis Hospital medical staff at the annual meeting recently. The staff now numbers 247.

Dr. Maurice W. Shertoli, 2340 Lincolnwood, Evanston, was named vice president and Dr. William L. Waner, 9340 Avers, Skokie, secretary-treasurer.

Dr. Irwin who has been on the St. Francis staff since 1926, is a graduate of Rush Medical school, 1921. He was appointed to the active staff in 1947, and previously, in 1941, he has joined the American College of Surgeons.

A member of the staff since 1941, Dr. Shertoli, is a graduate of St. Louis University School of Medicine, 1931. He was a graduate fellow in internal medicine at St. Louis University from 1932 to 34, and practiced in Missouri until he came to St. Francis. He was appointed to the active staff in 1950.

Dr. Irwin was vice president of the staff last year, and Dr. Shertoli was secretary-treasurer. Dr. Noel G. Shaw, 2819 Colfax, Evanston, was president last year.

Dr. Waner is also a graduate of Rush and he interned at St. Francis in 1925 and 26. He joined the staff in 1926. Both he and Dr. Shertoli served in the Armed Forces during the last war.

Annual Meeting of Hektoen Institute.—At the annual meeting of the board of directors of the Hektoen Institute for Medical Research of Cook County Hospital, December 9, the following were named to the board: Dr. S. Howard Armstrong, Jr., director of medical education, Cook County Hospital; Dr. Arthur Colwell, head of the department of medicine, Northwestern University Medical School; Dr. Harry Dowling, head of the department of medicine, University of Illinois College of Medicine; Dr. Chester C. Guy, chief of surgery, Illinois Central Hospital, and Mr. Charles F. Chaplin, county commissioner.

University News.—Eli Lilly and Company has renewed its grant for one year to support research on insulin and related subjects under the direction of Dr. M. E. Krahl in the department of physiology.

Dental Activities to Expand.— Northwestern University has announced plans for the construction of two dental school clinics which will rank among the finest of their kind in the nation.

Construction will begin this month on an oral surgery clinic and a diagnosis, treatment planning, and research clinic.

Both clinics will be in the Montgomery Ward building of the Northwestern Medical Center, on the University's Chicago campus, and will be completed before the end of the current academic year.

The oral surgery clinic, an expansion and modernization of existing facilities, will be located on the building's 11th floor and will provide 2,800 square feet of floor space. Scheduled for construction are two major operating rooms, three additional treatment rooms, a medical laboratory, preparation room, dark room, scrub room, and several sterilization areas. Present facilities include two operating rooms, an X-ray room, a recovery room, and offices.

The entire clinic area will be air-conditioned, primarily to assure a hygienic atmosphere for operations.

The new operating rooms will meet all the requirements of a modern hospital and will contain operating tables rather than chairs. They are intended for minor oral surgery in which a general anesthesia is required.

According to George W. Teuscher, dental school dean, the rooms have been designed especially for treatment of handicapped children who cannot be operated upon under a local anesthesia. These include palsied children, cardiac cases, and the mentally retarded.

"The new facilities will allow us to acquaint our students with the finest techniques in oral surgery," said Dean Teuscher.

The clinic will continue under the directorship of Dr. Orion H. Stuteville. Several anesthesiologists, physicians with special training in anesthesia, will be added to the staff when the clinic is completed.

The diagnosis, treatment planning, and research clinic will occupy 2,500 square feet of floor space on the building's 10th floor. Its facilities will include a physical examination room, photographic room with dark room, a second dark room for X-ray work, a teaching seminar room, 10 dental chairs and units, and a consultation office.

The diagnosis and treatment planning phases of the new clinic will deal with the patient before he is sent to the various treatment clinics of the school, said Dean Teuscher. The research aspect will provide students and faculty with the opportunity to re-examine completed work.

Dental school alumni will be invited to come to the clinic for advice and consultation on special problems.

In its diagnostic work, said Dean Teuscher, the clinic will treat not only with oral problems but will attempt a tie-in with medicine so that the "total patient" may be studied. He pointed out, for example, that early symptoms of many systemic diseases, such as nutritional aand vascular disorders, may appear in the mouth and can be recognized by a properly trained dentist.

New Appointments at State Hospital.—Recent appointments to the Chicago State Hospital include the following: Kalman Gyarfas, clinical associate professor of psychiatry, University of Illinois College of Medicine, superintendent; W. M. C. Harrowes, Edinburg University, Scotland, director of research and education; John Cowen, Raleigh, N.C., assistant superintendent (medical); Mr. John T. Taylor, formerly staff officer at General Douglas MacArthur's headquarters, assistant superintendent (non-medical); Ladislas J. Meduna, professor of psychiatry, University of Illinois College of Medicine, consultant in psychiatry; Rudolph G. Novick, associate clinical professor of psychiatry at Illinois, consultant in psychiatry; R. A. Fisher, a graduate of the University of Geneva Medical School, Switzerland, resident chest physician; Joseph Lloyd D'Silva, a graduate of Madras University, India, resident chest surgery; Miss Frieda Axen, R.N., formerly charge nurse at St. Elizabeth's Hospital, Washington, D.C., chief nurse, and Miss Catherine Hitchcock, R.N., formerly head nurse at St. Elizabeth's Hospital, assistant chief nurse.

Abraham J. Simon, Ph.D., executive director of the Jewish Child Welfare Association, St. Louis, has been administrator of the William Healy Residential School, West Side Medical Center. The school, now under construction for seriously emotionally disturbed children, will have a capacity of forty eight and be under the direction of the Institute for Juvenile Research of the Illinios Department of Public Welfare.

Symposium on Growth.—The Sigma Xi Club of Chicago Medical School presented a symposium. "Symposium on Growth," on Wednesday, February 9, at 7 p.m. in Amphitheatre "A" of the school.

"What is Growth?" was discussed by Dr. Paul A. Weiss, Director of the Laboratory of Developmental Biology, Rockefeller Institute for Medical Research; "Regulation of Bacterial Growth Rate"

by Dr. Aaron Novick, Assistant Professor of Microbiology and Member of the Committee of Biophysics, the University of Chicago; "Growth Hormone as a Factor in Somatic Growth" by Dr. Delbert Bergenstal, Assistant Professor of Medicine, the University of Chicago; and "Growth in Animal Lung Tumors" by Dr. Michael B. Shimken, Chief of the Biometry and Epidemiology Branch of the National Cancer Institute.

Dr. James G. Shaffer is president and Dr. Ben B. Blivaiss is program chairman of The Chicago Medical School Sigma Xi Club.

LIVINGSTON

Society Marks Seventy-Fifth Anniversary of Institute.—The Livingston County Medical Society devoted its meeting, December 9, to mark the seventy-fifth anniversary of the Keeley Institute, Dwight. Following the dinner, James Oughton, director of the institute, gave the welcoming address, and Dr. William A. Marshall, Dwight, gave the introductions. The principal speaker was Dr. Fred E. Lawrence, medical director for the Indiana State Commission on Alcoholism.

PIKE

New Officers.—Dr. J. H. Rutledge, Pittsfield, was elected president of the Pike County Medical Society, succeeding Dr. W. W. Kuntz, Barry. Other officers include W. R. Malony, Pittsfield; vice president M. Shulman, Pittsfield, secretary-treasurer; J. A. Vargas, delegate to the Illinois State Medical Society; Jacob Belagorsky, Barry alternate.

Fifty years of Practice.—At a recent meeting of the Pike County Medical Society, Dr. Russell P. Wells, Pleasant Hill, was inducted in the Fifty Year Club of the Illinois State Medical Society, having completed fifty years in the practice of medicine. The insigna commemorating the event, composed of a certificate and pin, was presented by Dr. F. Garm Norbury, Jacksonville,

Personal.—Dr. P. N. Chiasson has been elected president of the medical staff of the Illini Hospital, Pittsfield, succeeding Dr. Jacob Belagorsky.—Dr. James E. Goodman, Jr., Pleasant Hill, will return to his practice there on his discharge from the medical corps of the Navy in February. His wife and four children have been with Dr. Goodman in Japan since October 1953.

ROCK ISLAND

Society News.—Mr. Douglas Eastwood of Iowa University Clinics, Iowa City, discussed "Evaluation of the Cardiac for Anesthesia" before the Rock Island County Medical Society, January 11, at the Moline Public Hospital.

SANGAMON

Society News.—Dr. Thomas C. Baffes, assistant attending physician, Children's Memorial Hospital, Chicago, addressed the Sangamon County Medical Society, December 2, on "Current Trends in the Management of Congenital Heart Disease."

GENERAL

Population Increases.—The population of the United States, including members of the armed forces overseas, rose to 163,930,000 at the end of 1954, the Metropolitan Life Insurance Company's statisticians estimate.

This represents a gain of 2,830,000 during the year, and exceeds by more than 100,000 the previous high registered in 1951. It was the eighth year in succession, the statisticians note, in which the population gain has been more than 2.5 millions. Contributing to the 1954 gain were the new high number of births, an all-time low death rate, and a moderate addition through immigration.

Every state except West Virginia shared in the 1954 population increase. The rate of population growth was highest along the Pacific Coast, 3.7 percent, or approximately double the national gain of 1.8 percent. Since April of 1950 California, alone has added more than 2.3 million inhabitants. Its population now numbers about 12.9 million, and is exceeded only by that of New York State.

The Rocky Mountain States also experienced a vigorous population growth during the year. Arizona and Nevada have been the fastest growing states in the country, each having doubled its population since 1940.

Florida's population increased by about 5.7 percent in 1954, and by more than 6 percent annually in the years immediately preceding. Increases well above the national average also occurred in the District of Columbia and in New Mexico, Delaware, Maryland, Utah, Connecticut, Michigan, Louisiana and Texas.

Second International Congress of Allergology.—The Second International Congress of Allergology will be held, by invitation of the Brazilian Allergy Society, in Rio de Janeiro, November 6-13, 1955, under the chairmanship of Dr. F. W. Wittich, Minneapolis, Minnesota, President of the International Association of Allergology. A wide and extensive program dealing with almost all important problems of allergy and related immunology, biochemistry, pharmacology and thereapeutics has been elaborated, and is under preparation by the I. A. A. and the Brazilian Allergy Society.

Sir Henry H. Dale, London; Professor Pasteur Vallery-Radot, Paris; Professor Bernardo Houssay, Buenos Aires and Dr. Robert Cooke, New York City, have been invited as guest speakers. The official languages will be English, French, Portuguese and Spanish, and the main topics will be presented in these languages, although scientific communications and discussions may be presented in the native language of the author.

The scope of the program is wide, including symposia on: Histamine, drug allergy, hematology, chemistry of antigens and antibiotics, immunological techniques, electrolytic disturbances, hormones,

psychosomatics, dermatology, industrial allergy and allergy to microbes and parasites.

A fairly large number of scientific communications will be presented.

A very interesting program including scientific and technical exhibits, receptions, excursions, entertainments, banquets and also a ladies' program elaborated by the Brazilian Allergy Society will make of this Congress a never-to-be forgotten meeting.

North Americans wishing to present papers should send in their requests to Dr. Fred W. Wittich, 424 LaSalle Medical Building, Minneapolis 2, Minnesota.

All information concerning the Congress is available from the General Secretary of the I. A. A.: Dr. Bernard N. Halpern, 197 Boulevard Saint Germain, Paris VII°, France and from the Secretary of the Sociedade Brazileira de Alergia: Dr. Fabiano Alves, Avenida Rio Branco 2777° andar, sala 705, Rio de Janeiro, Brazil.

DEATHS

Pliny R. Blodgett*, Chicago Heights, who graduated at the University of Illinois College of Medicine in 1916, died December 20, aged 62. He was past president of the Illinois Academy of General Practice and former chief of staff of St. James Hospital in Chicago Heights.

Herbert Cuthbert Cantle*, Cropsey, who graduated at the University of Vermont College of Medicine in 1903, died October 13, aged 74.

Fremont A. Chandler*, Chicago, who graduated at Columbia University College of Physicians and Surgeons, New York, in 1919, died December 24, aged 61. He was professor and head of the department of orthopedic surgery at the University of Illinois College of Medicine and senior attending orthopedic surgeon at St. Luke's Hospital.

Leslie Dwight Dougherty*, Cowden, who graduated at Loyola University School of Medicine in 1917, died November 21, aged 62, of coronary thrombosis.

David John Davis*, retired, Wilmette, who graduated at Rush Medical College in 1903, died December 19, aged 79. He was dean emeritus of the College of Medicine and Professor of Pathology of the University of Illinois College of Medicine. He was permanent historian of the Illinois State Medical Society.

Henry P. Dorman*, Chicago, who graduated at the University of Illinois College of Medicine in 1932, died December 13, aged 56. He was a member of the staffs of Ravenswood Hospital, and St. Francis Hospital in Evanston.

Edward Merle Egan*, Chicago, who graduated at the Chicago Medical School in 1931, died January 4, aged 57. He was a former president of the South Shore Branch of the Chicago Medical Society and a member of the staff of South Chicago Community Hospital.

Hymen William Golub*, Chicago, who graduated at the University of Illinois College of Medicine in 1927, died December 24, aged 51. He was a member of the staff of the Holy Cross Hospital.

John D. Hardinger*, Gays, who graduated at Marion-Sims College of Medicine, St. Louis, in 1896, died December 28, aged 84. He was a member of the "Fifty Year Club" of the Illinois State Medical Society, a former mayor, and a member of the school board for 40 years.

Lewis R. Hill*, LaGrange, who graduated at the University of Illinois College of Medicine in 1926, died December 15, aged 58. He formerly was assistant professor of bacteriology and preventive medicine at Loyola University School of Medicine.

George Emmett Knappenberger*, Macomb, who graduated at Rush Medical College in 1909, died October 23, aged 70, of myocarditis.

Ernest Edward Ochsner*, Rockford, who graduated at Rush Medical College in 1896, died November 4, aged 85. He was a past president of the Winnebago County Medical Society, and one of the founders and served as president of St. Anthony Hospital; he was a member of the "Fifty Year Club" of the Illinois State Medical Society.

Clyde R. Landis*, Chicago, who graduated at the General Medical College, Chicago, in 1923, died December 23, aged 60.

Frederick A. Rettig*, Chicago, who graduated at the University of Illinois College of Medicine in 1922, died December 13, aged 57. He was attending staff surgeon at the Alexian Brothers and St. Joseph Hospitals, founder of the Alexian Brothers Hospital Foundation, and was a former president of the hospital's medical staff. He became a member of the American College of Surgeons in 1934.

Joseph Andrew Shacter, Chicago, who graduated at the University of Illinois College of Medicine in 1919, died November 25, aged 59. He was associate in surgery at Northwestern University Medical School, a member of the staff of Chicago Wesley Memorial Hospital, and a member of the American Psychosomatic Society and the International College of Surgeons.

James Charles Turek, retired, Chicago, who graduated at Rush Medical College in 1895, died December 22, aged 80.

William K. Yeakel*, retired, Chicago, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1899, died December 27, aged 89, in Wesley Gardens, Seattle. He was a member of the staff of the Ravenswood Hospital for many years.

**Member, Illinois State Medical Society.*

Pyridium®

(PHENYLAZO-DIAMINO-PYRIDINE HCl)

Gratifying relief from urinary distress in a matter of minutes

IMPORTANT BENEFITS: Well-tolerated, fast-acting urinary analgesic. Action confined to GU tract. Compatible with sulfas and antibiotics.



FOR COMFORT
ON THE JOB . . . AND AT PLAY

EFFECTIVE—In a clinical report covering 118 cases of pyelonephritis, cystitis, prostatitis and urethritis,[1] PYRIDIUM relieved or abolished pain and burning in 93% of the patients and decreased or eliminated nocturia in 83.7% of the cases.

NONTOXIC—Analgesia from PYRIDIUM is restricted to the urogenital mucosa. Concomitant administration of PYRIDIUM and sulfonamides or antibiotics is often desirable to relieve pain in the interval before the antibacterials can act.

PHYSIOLOGICAL—Through its local analgesic action, PYRIDIUM helps relax the sphincters, thus facilitating emptying of the bladder.

PSYCHOLOGICAL—The characteristic orange-red color of PYRIDIUM in the urine is often an immediate assurance to the patient of prompt action.

SUPPLIED—in 0.1 Gm. (1½ gr.) tablets, vials of 12 and bottles of 50, 500, and 1,000.

PYRIDIUM is the registered trade-mark of Nepera Chemical Co., Inc., for its brand of phenylazo-diamino-pyridine HCl. Sharp & Dohme, Division of Merck & Co., Inc., sole distributor in the United States.

SHARP & DOHME

PHILADELPHIA 1, PA.

DIVISION OF MERCK & CO., INC.

REFERENCE: 1. Kirwin, T. J., Lowsley, O. S., and Menning, J., Am. J. Surg. **62**:330-335, December 1943.

BOOK REVIEWS

RADIOLOGY OF BONES AND JOINTS
Edited by James F. Brailsford, M.D. Ph.D., F. R. C. P., F. I. C. S. (HON.) Fifth Edition. With Over 725 Illustrations. Published by The Williams & Wilkins Company. Copyright 1953. Price $19.00

This is a huge text profusely and well illustrated with radiographs and a few line drawings. This fifth edition attests to its popularity and over the past twenty years, since the original edition published in 1934.

Much of its value lies in the many follow up serial radiographs which have been made of bone tumors and bone dysplasias. However, the section on hypervitaminosis A is quite meager and that consists of quotes from other authors. He has no radiographs to illustrate this pathology.

The text is well organized and painstakingly documented. It deserves a place in every medical library. H. T.

‹ ›

ESSENTIAL UROLOGY. Second Edition
Edited by Fletcher H. Colby, M.D. Chief of the Urological Service, Massachusetts General Hospital; Associate Clinical Professor of Genito-Urinary Surgery, Harvard Medical School, Boston, Massachusetts; Urological Consultant, Lakeville State Sanatorium, Middleboro, Massachusetts. Published by The Williams & Wilkins Company, Baltimore. Published 1953. Price $8.00

This text is divided into three parts. The first section deals with the Embryology Anatomy and Physiology of the Genito-Urnary Organs.

Part two deals with the examination of the Urological Patient.

The third part deals with specific diseases of the components of the Genito-Urinary Organs.

It is profusely illustrated with excellent photographs, radiographs, and line drawings. The paper, print and blinding are above average. Each chapter is concluded with a bibliography as an aid to further study and investigation.

H. T.

‹ ›

ATLAS OF ORTHOPEDIC TRACTION PROCEDURES. Edited by Carlo Scuderi, B.S., M.D., M.S., Ph.D. Clinical Associate Professor of Surgery, University of Illinois; Professor of Surgery, Cook County Graduate School; Attending Surgeon, Cook County Hospital; Chairman of Department of Orthopedic Surgery, St. Elizabeth's Hospital and Columbus Hospital; Senior Orthopedic Surgeon, Alexian Brothers' and St. Anne's Hospitals; Consulting Orthopedic Surgeon, Augusta Hospital, Chicago. With 124 Illustrations. Published by The C. V. Mosby Company, St. Louis. Copyright 1954. Price $12.50.

This is the first time a text devoted entirely to orthopedic traction problems has been published. It is profusely illustrated with clear detailed photographs defining the vast majority of orthopedic traction procedures. When necessary, for greater detail and accuracy, line drawings have been used. The text is pithy, nicely and unobtrusively balances the photographic illustrations.

Interns and residents would find this book a gold mine of information which can be quickly adapted to immediate problems. The attending surgeon will find that much time can be saved

(Continued on page 62)

AUREO

MYCIN*

HYDROCHLORIDE
Chlortetracycline HCl *Lederle*

Stands on its record!



Seven years of world-wide use . . . more than half a billion doses administered . . . millions of patients restored to normal health, many saved from death—this is the unsurpassed record of AUREOMYCIN.

AUREOMYCIN, the first extensively prescribed broad-spectrum antibiotic, must certainly rank with the major therapeutic agents available.

Thousands of published clinical trials have established its efficacy in combating many kinds of infection. Thousands of doctors give it their highest acclaim by regularly employing it in their practices.

A convenient dosage form for every medical requirement. Lederle

*TRADE-MARK

Book Reviews (Continued)

and his explicit orders carried out with less confusion by simply referring to the appropriate photograph.

A timely text, well done. H. T.

‹ ›

A Manual of OTOLOGY, RHINOLOGY AND LARYNGOLOGY. Edited by Howard Charles Ballenger, M.D., F.A.C.S. Professors of Otolaryngology Emeritus and recently Chairman of the Department of Otolaryngology, Northwestern University Medical School, Chicago, Illinois. Surgeon, Department of Otolaryngology, Evanston Hospital, Evanston, Illinois, and John J. Ballenger, B.S., M.S., M.D., Associate, Department of Otolaryngology, Northwestern University Medical School, Chicago, Illinois. Member of the Surgical Staff, Department of Otolaryngology, Evanston Hospital, Evanston, Illinois. Fourth Edition, Enlarged and Thoroughly Revised, With 136 Illustrations and 3 Color Plates. Published By Lea & Febiger, Philadelphia. Copyright 1954. Price $6.00.

This popular manual is in many respects a very complete condensation of Dr. Ballenger's more comprehensive work on diseases of the nose, throat, and ear. It is designed primarily for the teaching of undergraduate students, but is of great value as ready reference for general practice.

This fourth edition has been extensively revised. The literary style is adequate and the illustrations informative. It is thought the inclusion of a bibliography might be extremely useful.

H. T.

‹ ›

BOOKS RECEIVED

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

HANDBOOK OF TREATMENT. By Harold Thomas Hyman, M.D., author of Integrated Practice of Medicine, Handbook of Differential Diagnosis. J. B. Lippincott Company, Philadelphia and Montreal. $8.00.

DIABETES MELLITUS, Objectives and Methods of Treat-

(*Continued on page* 64)

This drug has proved able
to control the disease
in two-thirds of patients
with ulcerative colitis,
who had previously failed to
respond to standard colitis
therapy currently in use*.

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY

Azulfidine
BRAND OF SALICYLAZOSULFAPYRIDINE

* See MORRISON: Rev. of Gastroent., Oct. 1953.

PHARMACIA LABORATORIES, INC.
270 Park Avenue, New York 17, N. Y.

when joints need "oiling"



Pabirin . . . safest of the antirheumatic salicylate-paba combinations

because . . . Pabirin does not produce salicylism even with heavy daily requirements. *High* blood levels are maintained with *low* salicylate dosage. It contains well-tolerated acetylsalicylic acid, the most effective of the salicylates. Pabirin is sodium- *and* potassium-free. A therapeutic amount of 300 mg. of ascorbic acid in the average daily dose of six capsules offsets depletion of vitamin C by salicylates.

And effective because . . . The synergistic effect of acetylsalicylic acid and PABA and the retarding action of PABA on salicylate excretion ensure high and sustained blood levels. Rapidly disintegrating capsules provide fast absorption and pain relief.

Pabirin is a DORSEY preparation.

Each capsule contains:
Acetylsalicylic acid ..... 5 gr.
Para-aminobenzoic acid ..... 5 gr.
Ascorbic acid ..... 50 mg.
Average dose: 2 to 3 capsules 3 or 4 times daily.
Supplied: In bottles of 100, 500 and 1,000 capsules.

Pabirin®

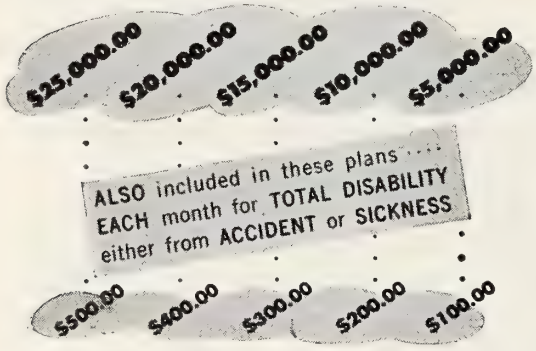
Smith-Dorsey • Lincoln, Nebraska • A Division of The Wander Company

Something NEW
is Cooking



MORE INSURANCE NOW AVAILABLE

think! HOW THESE AMOUNTS WOULD HELP IN PAYING ESTATE TAXES IN CASE YOU ARE ACCIDENTALLY KILLED . . .



SPECIFIC BENEFITS ALSO FOR LOSS OF SIGHT, LIMB OR LIMBS FROM ACCIDENTAL INJURY

$4,000,000 Assets
$20,000,000 Claims Paid
52 Years Old

Physicians Casualty & Health Ass'ns.
Omaha 2, Nebraska

Books received (continued)

ment. By Henry T. Ricketts, M.D., Professor of Medicine, University of Chicago, The School of Medicine, Chicago, Illinois. Charles C. Thomas, Publisher, Springfield, Illinois. $3.25.

THE KIDNEY, A Ciba Foundation Symposium. Arranged jointly with the Renal Association. Editor for the Renal Association, A. A. G. Lewis, M.D., B.S., B.Sc., M.R.C.P., Editor for the Ciba Foundation, G.E.W. Wolstenholme, O.B.E., M.A., M.B., B. Ch. Assisted by Joan Etherington. 125 illustrations. Little, Brown and Company, Boston, $6.75.

PATOLOGIA DEL ESTOMACO OPERADO. Segundo Congreso Argentino de Gastroenterologia. Editorial Universitaria, Paraguay 2074, Buenos Aires.

REPRODUCTIVE SYSTEM. By Frank H. Netter, M.D. Volume 2. The Ciba Collection of Medical Illustrations. Commissioned and Published by Ciba Pharmaceutical Products, Inc., Summit, New Jersey. Edited by Ernst Oppenheimer, M.D. With a foreword by John Rock, M.D., Clinical Professor of Gynecology, Harvard Medical School. $13.00.

TISSUE CULTURE TECHNIQUE IN PHARMACOLOGY. Annals of the New York Academy of Sciences. Volume 58, Art. 7, Pages 971-1326. Editor, Roy Waldo Miner. Consulting Editor, C. M. Pomerat. $4.50.

PAUL EHRLICH CENTENNIAL. Annals of the New York Academy of Sciences. Volume 59, Art. 2, pages 141-276. Editor, Roy Waldo Miner. Consulting B.Sc., —M.R.C.P., Editor for the Ciba Foundation, Editor, E. Grunberg. $3.00.

SPECIATION AND VARIATION IN ASECUAL FUNGI. Annals of the New York Academy of Sciences. Volume 60, Art. 1. Pages 1-182. Editor, Roy Waldo Miner, Consulting Editor, Kenneth B. Raper. $3.50.

6-MERCAPTOPURINE. Annals of the New York Academy of Sciences. Volume 60, Art. 2, Pages 183-508. Editor, Roy Waldo Miner. Consulting Editor, C. P. Rhoads. $4.50.

‹ ›

What next?

So far, civilized society, although it is slowly bettering our living and has made use less secure than in the past, has not brought us full security — we are a long way from that. The thin veneer of advancement is not even skin deep. Under adverse circumstances, a smaller aggressive modification in life could push us backward to primitiveness or savagery, the elements of which we still conserve within us. *B. Liber, M.D., Minor Physical and Mental Troubles. New York J. Med., Feb.* 15, 1954.

LIVITAMIN®

VITAMIN® with IRON
ch fluidounce contains:
on Peptonized.....
....420 mg.
quiv. in elemental iron to 70 mg.)
anganese Citrate, Soluble..
....158 mg.
iamine Hydrochloride.....
.... 10 mg.
boflavin.....
.... 10 mg.
tamin B 12 (Crystalline).....
.... 20 mcgm.
iacinamide.....
..... 50 mg.
yridoxine Hydrochloride.....
..... 1 mg.
antothenic Acid.....
..... 5 mg.
iver Fraction 1.....
..... 2 Gm.
ice Bran Extract.....
..... 1 Gm.
nositol.....
..... 30 mg.
holine.....
..... 60 mg.

IVITAMIN® CAPSULES with
NTRINSIC FACTOR
ach capsule contains:
Desiccated Liver.....
.....450 mg.
Ferrous Sulfate.....
.....130 mg.
(Equiv. to 25 mg. of elemental iron)
Thiamine Hydrochloride.....
..... 3 mg.
Riboflavin.....
..... 3 mg.
Niacinamide.....
..... 10 mg.
Vitamin B 12.....
..... 5 mcgm.
Pyridoxine Hydrochloride.....
.....0.5 mg.
Calcium Pantothenate.....
..... 2 mg.
Folic Acid.....
..... 1 mg.
Intrinsic Factor USP.....
.....1/6 Unit

S.E. MASSENGILL

debilitating syndrome

ANEMIA is usually a symptom, but present also are anorexia, anoxia, hypothermia, hypotonia and poor utilization. Often a finicky diet will aggravate the general asthenia.

. . . SYNDROME THERAPY IS LOGICAL . . .

Fortified Iron therapy in the Livitamin formula treats the entire syndrome. Improved appetite and blood picture, better digestion and anabolism are part of the corrective process.

LIVITAMIN with INTRINSIC FACTOR

The pernicious anemia patient and many aging people are deficient in intrinsic factor. For these patients, special Livitamin Capsules have been fortified with adequate intrinsic factor, USP, to help provide full utilization of the antianemic factors in the Livitamin formula.

THE RECONSTRUCTIVE IRON TONIC OF WIDE APPLICATION





LIVITAMIN®

geriatrics
obstetrics-gynecology
pediatrics
convalescence
surgery

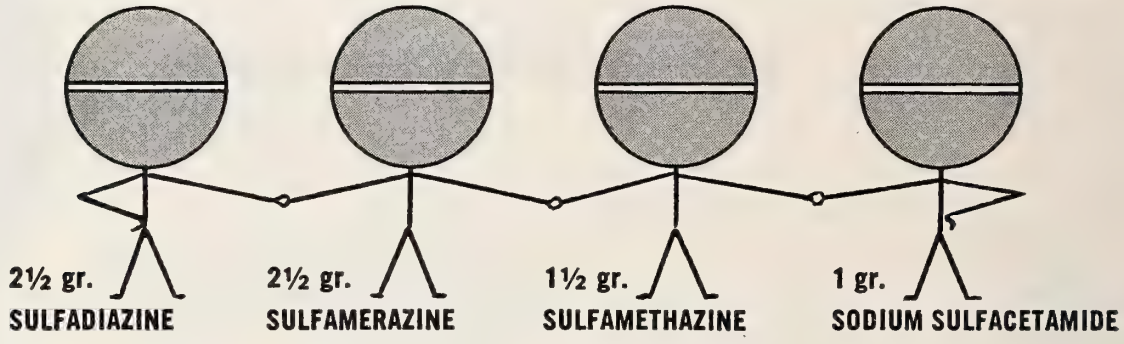
The brain

Day and night, from childhood to old age, sick or well, asleep or awake, men and women think. The brain works like the heart, ceaselessly pulsing. In its three pounds' weight of tissue are recorded and stored billions upon billions of memories, habits, instincts, abilities, desires, hopes, and fears, patterns and tinctures and sounds, and inconceivably delicate calculations and brutishly crude urgencies, the sound of a whisper heard thirty years ago, the resolution impressed by daily practice for fifteen thousand days, the hatred cherished since childhood, the delight never experienced but incessantly imagined, the complex structure of stresses in a bridge, the exact pressure of a single finger on a single string, the development of ten thousand different games of chess, the precise curve of a lip, a hill, an equation, or a flying ball, tones and shades and glooms and raptures, the faces of countless strangers, the scent of one garden, prayers, inventions, crimes, poems, jokes, tunes, sums, problems unsolved, victories long past, the fear of hell and the love of God, the vision of a blade of grass and the vision of the sky filled with stars. *Gilbert Highet, Man's Unconquerable Mind.*

‹ ›

Sex, violence, and intoxication

Most people have more to lose than to gain by antisocial actions: property, a job, marriage and children, the thought of illness and age, the fear of disgrace restrain them. But many young men and some girls between 15 and 25, and some groups and individuals after 25, are temporarily or/permanently rebels. To win them over and use their talents for their own benefit and ours, we must calm them down, divert their energies into harmless channels, commend regularity, and diminish harmful excitement. Such excitement is most dangerous in three areas — sex, violence, and intoxication. Therefore, it is generally thought wise to limit the free dissemination of knowledge in these areas. *Gilbert Highet, Man's Unconquerable Mind.*



Only FOUR-SULFA Gives

- **GREATEST POTENCY against the greatest number of infections.**
- **Broader bacteriostatic activity.**
- **Excellent tissue distribution with MINIMUM TOXIC REACTIONS — maintaining highest blood levels.**

Bottles of 1000, 500, 100 Yellow, Scored Tablets

Write for Literature and Prices

THE ZEMMER CO.
3943 Sennott St. Pittsburgh 13, Pa.

The long and short of Bentyl's relief of nervous gut

Clinicians[1,2] prove Bentyl is long on effective relief... short on unwanted side effects including blurred vision and dry mouth.

1. McHardy and Browne: Sou. Med. J. 45:1139, 1952. 2. Lorber and Shay: Fed. Proc. 12:90, 1952.

Complete Bentyl bibliography on request.

BENTYL

(Dicyclomine Hydrochloride)

another exclusive development of Merrell research

Rx INFORMATION

BENTYL

Bentyl affords direct (musculotropic) and indirect (neurotropic) spasmolytic action. Bentyl provides complete and comfortable relief in smooth muscle spasm; particularly in functional G.I. disorders, in irritable colon, pylorospasm, biliary tract dysfunction and spastic constipation.

Composition: Each capsule or teaspoonful (5 cc.) contains 10 mg. of Bentyl (dicyclomine hydrochloride).
Bentyl with Phenobarbital adds 15 mg. of phenobarbital to the preceding formula.

Dosage: *Adults,* 2 capsules or 2 teaspoonfuls of syrup, three times daily, before or after meals. If necessary, repeat dose at bedtime. *In Infant Colic,* ½ to 1 teaspoonful, ten to fifteen minutes before feeding.

Supplied: Bentyl — In bottles of 100 and 500 blue capsules, and Bentyl Syrup in pint and gallon bottles. Bentyl with Phenobarbital — In bottles of 100 and 500 blue-and-white capsules, and Bentyl Syrup in pint and gallon bottles. T.M. 'BENTYL'

Merrell
Since 1828

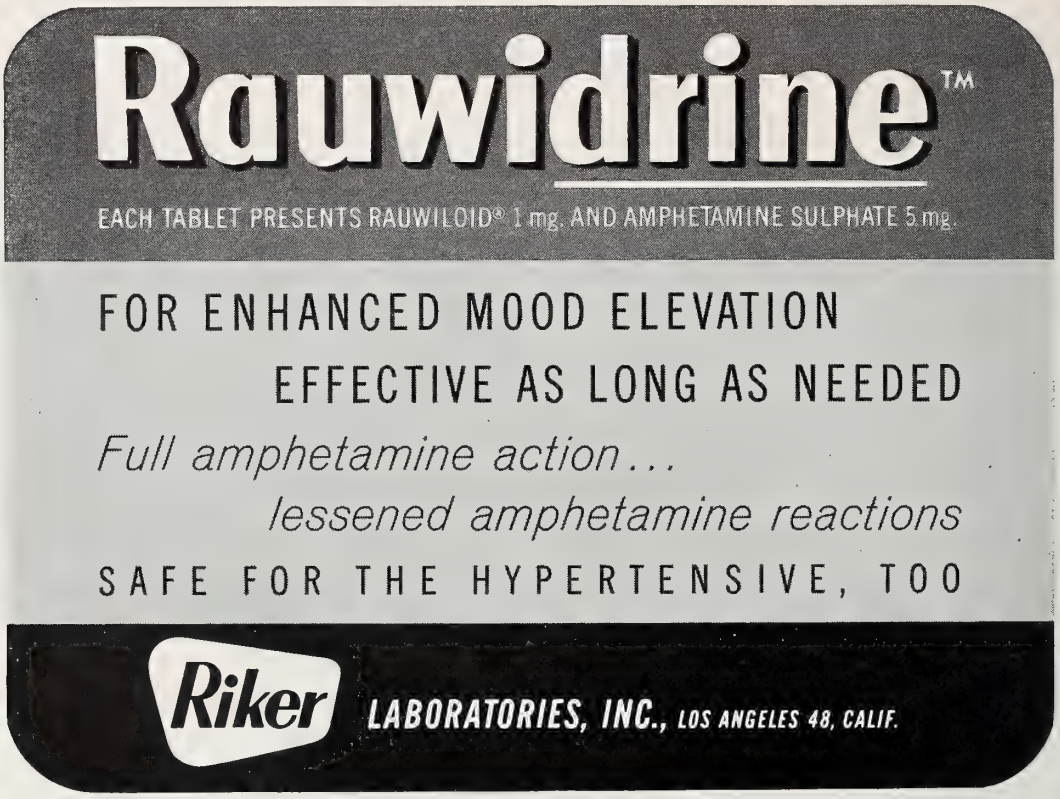
PIONEER IN MEDICINE FOR OVER 125 YEARS

THE WM. S. MERRELL COMPANY New York • CINCINNATI • St. Thomas, Ontario

Ulcerative colitis

At a symposium on ulcerative colitis before the American Proctologic Society, June, 1953, in which the participants were Chester M. Jones, Richard B. Cattell, and Leland S. McKittrick, of Boston, and R. P. Turnbull, of Cleveland, many points of interest and value were brought out.

Jones has seen the onset of the disease in patients from 4 to over 70, with the majority in the late teens or early 20's, and about an equal sex distribution. Starting usually in the rectum, the disease extends occasionally into the ileum. Recurrences tend to be precipitated by unexpected and undesired pregnancies, emotional or physical trauma, intercurrent infections, or gross dietary indiscretions, though the last are often tolerated if the other factors are not present. Jones mentions the wide variation in severity of the disease, the rarity of perforation, the seriousness of gross hemorrhages, and the occurrence of perianal sepsis, fissures, and fistulas as complications. Joint involvement occurs in about 10 per cent of cases and is not always, though often, cured by colectomy. Skin eruptions are common and occasionally large, necrotizing lesions appear. Eye involvement may be serious. Occasionally renal calculi and cirrhosis of the liver are seen, but only one liver abscess has been observed in Jones' 30 years of practice. Occasionally endocarditis, septicemia, and endocrine disturbances, such as amenorrhea, occur. Fluid balance is often a problem, especially after surgery. Jones believes that sulfonamides for fever are usually better than the antibiotics. He does not believe in rectal or colonic irrigations in this disease but emphasizes the value of an adequate, nutritious diet in treatment. Barbiturates are useful for relaxation. Patients often tolerate a planned pregnancy very well but are upset by unexpected and undesired pregnancy. There are two main indications for operation: to save life and to rehabilitate a chronically ill patient. *E. Parker Hayden, M.D., Proctology. New England J. Med. Aug.* 26, 1954.





Important!

Folic Acid

The importance of Folic Acid not only in red blood cell formation but in over-all nutrition is now established. When you prescribe a vitamin regimen, particularly for an infant or for a mother-to-be, select a product that contains Folic Acid. Most leading pharmaceutical manufacturers include this member of the vitamin B complex in their multivitamin preparations. This message is presented on their behalf.

Cyanamid
Fine Chemicals

AMERICAN *Cyanamid* COMPANY, Fine Chemicals Division, 30 Rockefeller Plaza, New York 20, New York

Do You Know ? ? ?

THE SPECIAL DISABILITY PLAN

AVAILABLE TO MEMBERS OF

THE ILLINOIS STATE MEDICAL SOCIETY

Provides Benefits up to . .

$5000. ACCIDENTAL DEATH AND DISMEMBERMENT

$100. PER WEEK FOR TOTAL LOSS OF TIME as the result of either Sickness or Accident.
$15. DAILY HOSPITALIZATION for up to 90 days as the result of either Sickness or Accident.

Plus . . .

Optional 5 Year Sickness Coverage
No reduction in benefits because of other insurance
Full benefits to age 70 at same cost
(All Benefits Subject to Provisions of the Policy)

FOR ALL THE FACTS - - -
Write or Telephone

PARKER, ALESHIRE & COMPANY

175 W. JACKSON BOULEVARD
Chicago 4, Ill. **WAbash 2-1011**

DOCTOR! you will approve the 3C's
Comfort, Cleanliness, Convenience



at Bee Dozier's **3** Sanitariums for

Aged, Chronic, Senile, Convalescent Patients.

Hickory Hill,
Maple Hill, *Palatine*

Charming, healthful rural locations conveniently situated, 24 hour care by trained nurses and orderlies, tempting food and supervised diets all contribute to your patient's well-being or recovery. 18 years of experience.

ONE rate covers EVERYTHING. There are NO extras.

Bee Dozier invites your inspection. Write Box 288, Lake Zurich, Ill., or Phone 4661

Antibodies against sperm

Antigenicity of body-own substances has often been investigated, and the possible role of auto-antibodies in disease has been widely discussed. However, the technical difficulties in obtaining evidence are great. In two fields only has important progress been made. The first is that of the antigens of the Wassermann and Forssman group. The second concerns the corpuscular constituents of the blood. Here the results have indeed been spectacular.

A remarkable report on an auto-antibody is found in the current issue of the Proceedings of the Society for Experimental Biology and Medicine (Vol. 86 p.652). It occurs in a system other than the blood. In two male subjects, an agglutinating antibody agains spermatozoa was discovered in significant titers, present both in the serum and in the seminal plasma. All human spermatozoa tested, including those of the subjects, were clumped. Both subjects were sterile, but no impairment of the spermatozoa excepting these antibodies could be detected. Whether the immune reaction provides a clew for the explanation of the sterility remains to be seen. But above and beyond this question, the general bioligical interest of these observations is obviously great.

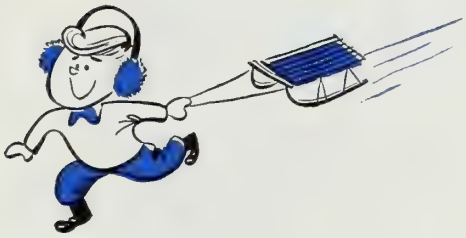
The work was done by a busy physician (Leo Wilson) who had no more technical apparatus than a microscope, a centrifuge, and an incubator. In these days of large research organizations and complex instrumentation, it is good to see that important contributions to medical science still can be made with simple technics if the investigator retains the ability to observe and the willingness to take pains. *Editorial, Auto-Antibodies Versus Spermatozoa. Ann. Allergy July-Aug. 1954.*

‹ ›

The small print

When yielding to the glowing appeals of protagonists of life, health, and accident insurance policies, beware of the small print in the proposed contracts. Often the company's safeguard is the small print. Even so, it's well for the policy holder to know just where the small print cuts him off. *Editorial, Small Print. J. Oklahoma M.A., July* 1954.

They've heard the call for



A full day's serving of eight important vitamins (including 3 mcg. of body-building B_{12}) in each spoonful. Delicious lemon-candy flavor and aroma. No pre-mixing, no droppers, no refrigeration. Mixes easily in milk, cereals or juices. Now with B_6 added. Sold in 90-cc., 8-fluid-ounce and economical one-pint bottles.

Abbott®

VI-DAYLIN®

(HOMOGENIZED MIXTURE OF VITAMINS A, D, B_1, B_2, B_6, B_{12}, C AND NICOTINAMIDE, ABBOTT)

the nutritional formula for growing children

Each 5-cc. teaspoonful of Vi-Daylin contains:

Vitamin A	3000 U.S.P. units
Vitamin D	800 U.S.P. units
Thiamine Hydrochloride	1.5 mg.
Riboflavin	1.2 mg.
Pyridoxine Hydrochloride	0.5 mg.
Ascorbic Acid	40 mg.
Vitamin B_{12}	3 mcg.
Nicotinamide	10 mg.

501057

THE
MEDICAL PROTECTIVE
COMPANY
FORT WAYNE, INDIANA

PROFESSIONAL PROTECTION
EXCLUSIVELY
SINCE 1899

specialized service
assures *"know-how"*

CHICAGO Office:
T. J. Hoehn, E. M. Breier and
W. R. Clouston, Representatives,
1142-44 Marshall Field Annex Building,
Telephone State 2-0990

SPRINGFIELD Office:
F. A. Seeman, Representative,
Telephone Springfield 4-2251



LINCOLNVIEW
Hospital and Sanitarium
Springfield, Illinois
8th & Capitol

Albert P. Ludin, M. D., Medical Director

MENTAL-ALCOHOLIC-ADDICTED

Rapid Intensive Treatment

Registered A.M.A. Licensed State of Illinois

Phone 2-3303

BELLEVUE PLACE

For
NERVOUS and MENTAL
DISEASES

★

Edward Ross, M.D., Medical Director
BATAVIA PHONE
ILLINOIS BATAVIA 1520

More on smoking and cancer of the lung

Dr. Ernest L. Wynder, of the Sloan-Kettering Institute, research Unit of the Memorial Center for Cancer and Allied Diseases, New York, told the Sixth International Cancer Congress at Sao Paulo, Brazil, on July 27 that data from 12 studies covering 6,000 lung cancer patients in various countries led him to conclude that smoking is a direct cause of cancer. He listed these 10 points to substantiate his belief:

Cancer of the lung rarely is found in nonsmokers.

There is a direct relationship between the amount smoked and the incidence of cancer.

There is a definite increase in the lung cancer death rate in countries where there is a marked increase in tobacco consumption.

The increase in lung cancer is greater among men than women; and men more frequently are heavy smokers.

There is a slight increase in lung cancer among women that parallels an increase in smoking by women.

The incidence of the disease is greater in cities than in the country, corresponding to greater cigarette consumption in cities.

Most lung cancers are of a type usually caused by irritants.

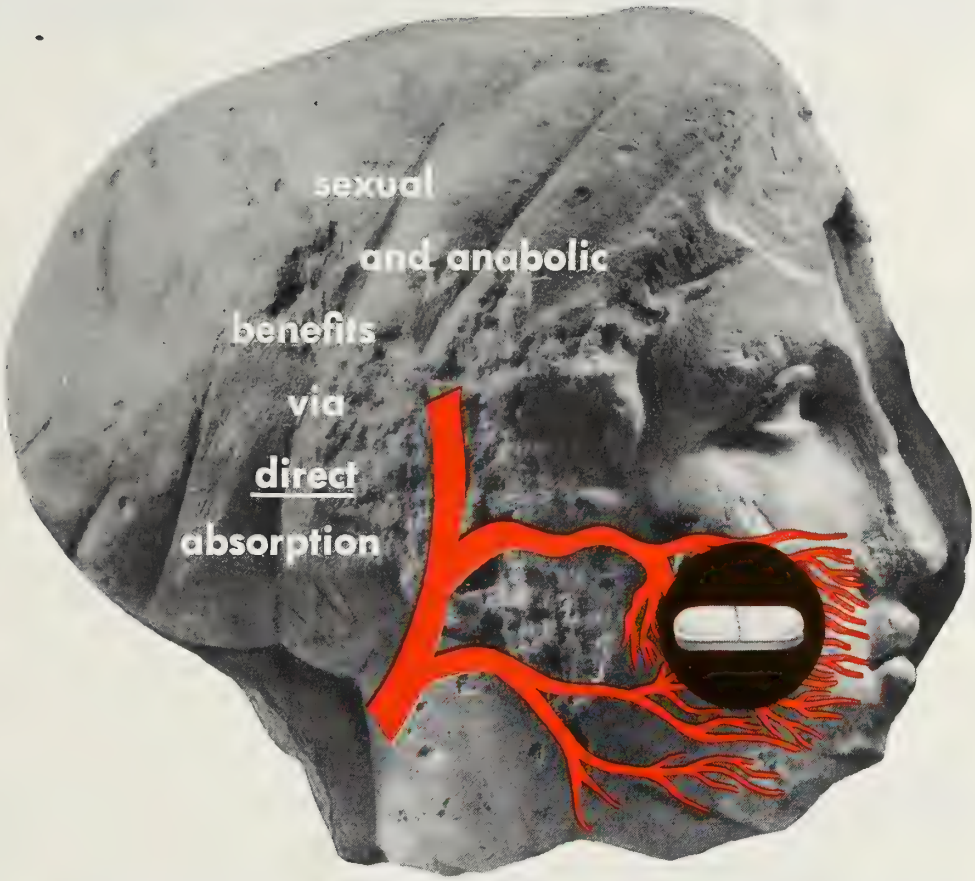
Similar cancers have been produced on the skin of animals by application of the condensate from cigarette smoke.

Nonsmokers who get lung cancers are exposed to other irritants.

Lung cancer among nonsmokers not exposed to other irritants generally is not the epidermoid type that smokers get. *Editorial, Wynder Blames Smoking. Philadelphia Med. Aug. 13, 1954.*

‹ ›

We all crave happiness, and we have at hand the predisposing conditions which make it possible. Nevertheless, the fact remains that to pursue happiness deliberately is not the surest way of achieving it. Seek it for its own sake and I doubt whether you will find it. The man who sets out to be gay Bohemian becomes a hopeless tragedian. *Robert J. McCracken, D. D.*



METANDREN® LINGUETS®

the most potent oral androgen

FEMANDREN® LINGUETS®

the most potent oral estrogen with the most potent oral androgen

Buccally or sublingually absorbed LINGUETS by-pass liver inactivation or gastric destruction—are virtually as potent as parenteral steroids—provide effective, convenient, low-cost hormone therapy.

Supply: Metandren Linguets, 5 mg. (white, scored) and 10 mg. (yellow, scored). Femandren Linguets (green, scored), each containing 0.02 mg. ethinyl estradiol and 5 mg. methyltestosterone.

Metandren® (methyltestosterone U.S.P. CIBA)
Femandren® (methyltestosterone with ethinyl estradiol CIBA)
Linguets® (tablets for mucosal absorption CIBA)

C I B A Summit, N. J.

2/ 2079M

The NORBURY SANATORIUM

JACKSONVILLE, ILLINOIS — INCORPORATED and LICENSED

For the Treatment of Nervous and Mental Disorders

FRANK GARM NORBURY, M.D., Medical Director
HENRY A. DOLLEAR, M.D., Superintendent
FRANK B. NORBURY, M.D., Associate Physician

Address Communications — THE NORBURY SANATORIUM, Jacksonville, Illinois

Mercy Hospital Institute of Radiation Therapy

The Henry Schmitz Medical Group

For Appointment
VIctory 2-4700, Ext. 170 or RAndolph 6-4444

Herbert E. Schmitz, M.D., *Director*
Peter A. Nelson, M.D., *General Oncology*
Henry L. Schmitz, M.D., *Internal Medicine*
Janet Towne, M.D., *Gynecology*
Robert L. Schmitz, M.D., *General Surgery*
John F. Sheehan, M.D., *Pathologist*
Charles J. Smith, M.D., *Gynecology*
Charles S. Gilbert, M.D., *Internal Medicine*
William F. Cernock, M.D., *Internal Medicine*
Fred W. Eims, *Physicist*
Miss Hilda Waterson, R.N.
Helen Hansen, *Social Service*

COMPLETE TUMOR THERAPY
Including
SUPERFICIAL X-RAY THERAPY
DEEP X-RAY THERAPY up to 1,000 K.V.
RADIUM THERAPY

Daily Consultation at Institute
Tumor Clinic—Mercy Free Dispensary—Tuesday at 9 a. m.
Tumor Conference — J. B. Murphy Auditorium — Friday at 1 p. m.

Our obligations

The physician must possess and exercise the degree of skill and care which ordinarily characterizes the profession.

The general practitioner is not expected to have the skill of a specialist but he must keep up with the generally accepted modern developments; and the corollary of this rule is that a specialist is held to a higher degree of skill than the general practitioner.

Any departure from approved methods in general use, resulting in injury to the patient, renders the physician liable no matter how good his intentions may have been.

A general practitioner who discovers, or should have known, that the patient's condition is beyond his knowledge or technical skill, is under a duty to disclose the fact to his patient and to advise him of the need for other or different treatment.

A physician is not obliged to treat any patient, nor on terms that are not suitable to him; but if he undertakes to do so, he cannot discontinue it without affording the patient a reasonable opportunity to engage another physician.

North Shore Health Resort

on the shores of Lake Michigan
WINNETKA, ILLINOIS

NERVOUS and MENTAL DISORDERS
ALCOHOLISM and DRUG ADDICTION
Modern Methods of Treatment
MODERATE RATES

Established 1901 — *Fully Approved by the*
Licensed by State of Illinois — *American College of Surgeons*

SAMUEL LIEBMAN, M.S., M.D.
Medical Director

225 Sheridan Road — Winnetka 6-0211

FAIRVIEW
Sanitarium

DEVOTED TO THE ACTIVE TREATMENT OF

MENTAL and NERVOUS DISORDERS

Specializing in Psycho-Therapy, and Physiological therapies including:

- Electro-Shock
- Electro-Narcosis
- Insulin Shock
- Carbon Dioxide Therapy

Out Patient Shock Therapy Available

ALCOHOLISM Treated by Comprehensive Medical-Psychiatric Methods.

2828 S. PRAIRIE AVENUE, CHICAGO 16 J. DENNIS FREUND, M. D., Medical Director

Phone Victory 2-1650 Registered by the American Medical Assn.

A physician is not liable for an honest mistake of judgment in either diagnosis or treatment.

Where there is a difference of opinion as to the proper method of treatment, a physician is not responsible provided he follows a course approved by a substantial number of reputable physicians in his community. *Charles E. Kenworthey, Legal Aspects Of Medical Practice, Pennsylvania M. J. Aug. 1954.*

‹ ›

Tic Doulourex

The response of patients with trigeminal neuralgia to 1,000 microgram daily doses of vitamin B_{12}, administered subcutaneously, has been notable enough to make it well worth a trial. Some patients with this condition respond well to oral doses of nicotinic acid sufficient to cause flushing and tingling of the skin (100 to 500 mg.). These two types of medical treatment have lessened the number of cases requiring alcohol injection or posterior root section. *F. Keith Bradford, M.D. Texas J. Med., Oct.* 1954.

Miami Heart Institute

A non-profit Cardio-vascular Center
Endorsed by Florida Heart Association

Accommodations for
ambulant patients and guests

Recreation—Research—Rehabilitation

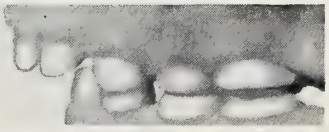
Staff open to Dade County
Medical Association

4701 N. Meridian Avenue,
Miami Beach, Fla.

On Beautiful Surprise Lake.

THUMBSUCKING

since infancy caused this malocclusion.



THUM
TRADE MARK

THUM broke the habit and teeth returned to normal position.

ACCEPTED FOR ADVERTISING IN PUBLICATIONS OF THE AMERICAN MEDICAL ASSOCIATION

Get Thum at your druggist or surgical dealer.
Prescribed by physicians for over 20 years.

in whooping cough

ELIXIR BROMAURATE

GIVES EXCELLENT RESULTS

Cuts short the period of illness and relieves the distressing spasmodic cough. Also valuable in Bronchitis and Bronchial Asthma.

In four-ounce original bottles. A teaspoonful every 3 to 4 hours.

Prescribed by Thousands of Doctors

GOLD PHARMACAL CO. NEW YORK CITY

Cause of acute pancreatitis

The reflux of bile into the pancreatic ducts as a cause of pancreatitis is stressed by some authors and denied by others. I personally feel that if infection exists in the biliary tract, it can be transmitted to the pancreas, possibly through the ducts or by way of the lymphatics. If infection is not present in the biliary tract, I am not convinced that a reflux of bile into the pancreatic ducts can produce an acute pancreatitis. In the experimental animal, the injection of bile into the pancreatic ducts did not produce pancreatitis unless it was administered at a very high pressure, far greater than the secretory pressure of the liver. Therefore, it does not seem physiologically possible for reflux of normal bile to sufficiently disrupt the small ducts within the pancreas to produce an acute pancreatitis. The theory that the reflux of bile into the pancreatic ducts produces pancreatitis is the basis for the operation, sphincterotomy, as a treatment for chronic pancreatitis. *Charles B. Puestow, M. D. Benign Pancreatic Disease. J. Louisiana M. Soc. Sept. 1954.*

Health problems

The challenging words of a great physician and distinguished public health administrator, Hermann Biggs, have been borne out: "Public health is purchasable and within certain limitations, communities may determine their own death rates." This has been convincingly demonstrated by the lower morbidity and mortality rates in communities willing to expend funds for the purchase of health. An equally significant pronouncement—"We are living in the century of the child"—is shown by the tremendous improvement in the field of infant and child health during the last 50 years. and disciplines of the medical profession. The health problems of tomorrow, as I see them, must be solved in the offices of physicians and health departments and in outpatient and hospital facilities. *Charles F. Wilinsky, M. D., The Relation Of Hospitals And Health Departments In Tomorrow's World. New England J. Med. Aug. 26, 1954.*

Redisol®

CRYSTALLINE VITAMIN B_{12}

versatile and potent antianemic agent

MAJOR ADVANTAGES: Remits the disabling symptoms of pernicious anemia. Stimulates hemopoiesis. Builds up appetite.

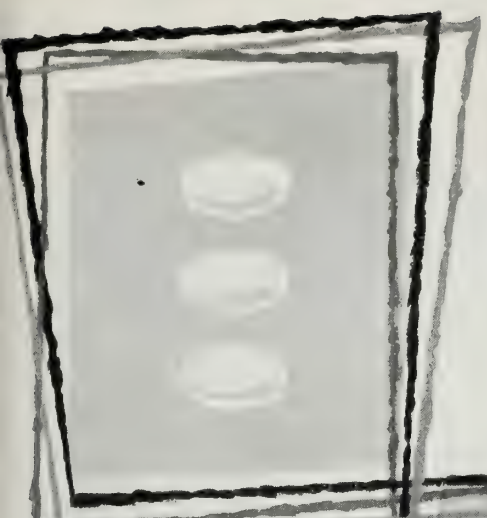
Small doses of vitamin B_{12} produce the same response in pernicious anemia as injections of potent liver extracts. REDISOL—pure vitamin B_{12}—also produces similar results in many cases of nutritional macrocytic anemia, megaloblastic anemia of infancy, tropical and non-tropical sprue.

Available as REDISOL *Tablets,* 25, 50, 100, 250 *mcg.;* REDISOL *Elixir, 5 mcg.* per 5 cc.; and REDISOL *Injectable,* 30, 100 and 1,000 *mcg.* per cc.

SHARP & DOHME

Philadelphia 1, Pa.
DIVISION OF MERCK & CO., INC.

for a more
optimistic outlook
for the rheumatoid patient





relieve pain...

promote recovery...

PABALATE...Each enteric coated yellow tablet contains 0.3 Gm. (5 gr.) of sodium salicylate, 0.3 Gm. (5 gr.) of para-aminobenzoic acid (as the sodium salt), and 50 mg. of ascorbic acid.

PABALATE-SODIUM FREE...Each enteric-coated, Persian rose colored tablet contains 0.3 Gm. (5 gr.) of potassium salicylate, 0.3 Gm. (5 gr.) of para-aminobenzoic acid (as the potassium salt), and 50 mg. of ascorbic acid.

PABALATE®

Robins

PABALATE-SODIUM FREE

A. H. ROBINS CO., INC., Richmond 20, Va. • *Ethical Pharmaceuticals of Merit since 1878*

Minor mental troubles

If most laymen and some physicians remain unconvinced, in the face of many moderately advanced mental cases, so much less would they consider anyone as mentally ill if he suffered from a disorder which — although sometimes a torment to the patient — is hardly noticeable outwardly, and never at a first glance. Such disturbances, however, are frequent. They are transitions between mental health and mental disease. Their existence has been noted and described by psychiatrists, but insufficient attention has been paid to them. They are neglected or dismissed as unimportant. They are regarded as less interesting than the fully developed psychoses or the unpleasant and disturbing neuroses. The more exceptional, the more advanced, the more unusual, the rarer cases fascinate our specialists more intensely. The more difficult the solution of his mental problem, the more welcome is the patient. The more intricate the diagnosis, the stronger the appeal of the case to the mental physician's imagination. *B. Liber, M.D., Minor Physical and Mental Troubles. New York J. Med., Feb.* 1954.

‹ ›

The control of vomiting and hiccough

Vomiting, though usually transitory, sometimes is a most aggravating problem. It can be particularly onerous in association with diseases in which hemorrhage in the upper gastrointestinal tract is a hazard, or following certain operations on the eyes or in cases of idiosyncratic reaction to drugs. Hiccough is not as prevalent as emesis but at times can be just as disturbing to the patient. When persistent in elderly patients in the postoperative period, it may be of grave prognostic purport. Chlorpromazine, a central nervous system depressant, is a new therapeutic agent for the control of vomiting and hiccough. This compound has two diverse applications: one as anti-emetic, the other as a depressant for managing excessive psychomotor activity. *B. Lyman Stewart, M.D. and A. G. Redeker, M.D., Emesis and Hiccough. California Med., Sept.* 1954.



"Folks say I don't look 60. Well, I don't feel it, either!"



For many a spry oldster, the only change noticeable with advancing age is that each succeeding birthday cake has one more candle on it. To help such persons grow old gracefully, productively, and happily, a supplementary supply of vitamins and minerals may be desirable. GEVRAL* provides 14 vitamins and 12 minerals in one convenient capsule for geriatric use.

Gevral*

Geriatric Vitamin-Mineral Supplement Lederle

Lederle LABORATORIES DIVISION AMERICAN Cyanamid COMPANY Pearl River, New York

EACH GEVRAL *CAPSULE CONTAINS:*

Vitamin A (acetate)	5000 U.S.P. Units (125% MDR)
Vitamin D (viosterol)	500 U.S.P. Units (125% MDR)
Vitamin B_{12}	1 microgram
Purified Intrinsic Factor Concentrate	0.5 mg.
Thiamine Hydrochloride (B_1)	5 mg. (500% MDR)
Riboflavin (B_2)	5 mg. (250% MDR)
Niacinamide	15 mg.
Folic Acid	1 mg.
Pyridoxine Hydrochloride (B_6)	0.5 mg.
Calcium Pantothenate	5 mg.
Choline Dihydrogen Citrate	100 mg.
Inositol	50 mg.
Ascorbic Acid (C)	50 mg. (166% MDR)
Vitamin E (tocopheryl acetates)	10 I. U.
Rutin	25 mg.
Iron ($FeSO_4$)	10 mg. (100% MDR)
Iodine (KI)	0.5 mg. (500% MDR)
Calcium ($CaHPO_4$)	145 mg. (19% MDR)
Phosphorus ($CaHPO_4$)	110 mg. (14.6% MDR)
Boron ($Na_2B_4O_7 \cdot 10H_2O$)	0.1 mg.
Copper (CuO)	1 mg.
Fluorine (CaF_2)	0.1 mg.
Manganese (MnO_2)	1 mg.
Magnesium (MgO)	1 mg.
Potassium (K_2SO_4)	5 mg.
Zinc (ZnO)	0.5 mg.

MDR—minimum daily requirement for adults

Lederle offers a *complete* geriatric line including: GEVRABON*, a vitamin-mineral supplement liquid with a wine flavor; GEVRAL* Protein, a vitamin-mineral-protein powder; and GEVRINE*, a vitamin-mineral-hormone capsule.

*REG. U.S. PAT. OFF.



MARY POGUE SCHOOL, Inc.

Complete facilities for training retarded and epileptic children educationally and socially. Pupils per teacher strictly limited. Excellent educational, physical and occupational therapy programs.

Recreational facilities include riding, group games, selected movies under competent supervision.

Separate buildings for boys and girls under 24 hour supervision of skilled personnel.

Catalog on request

G. H. Marquardt, M.D. · *Medical Director*

Barclay J. MacGregor *Registrar*

33 GENEVA ROAD, WHEATON, ILLINOIS

(near Chicago)

Classified Ads

VACANCIES IN MENTAL HOSPITALS: RESIDENTS IN PSYCHIATRY. Five year program consisting of three years in residency training and two years of employment in an Ill. mental hospital, qualifying for the examination by the American Board of Psychiatry and Neurology in an approved mental hospital facility, eligible for licensure as a physician in Ill. Salary: $5,000 per year. CONTACT: Percival Bailey, M.D., Director, State Psychopathic Institute, 912 So., Wood St., Chicago, Illinois.

VACANCIES IN MENTAL HOSPITALS:—PHYSICIANS: (3 levels) Physician I, $380 to $550 mo., less maint; Physician II, $500-$600 mo, less maintenance; Physician III, $550 to $720 mo., less maint. Psychiatrist I, $500 to $660 mo., less maint.; Psychiatrist II, $600-$785 mo., less maint.; Psychiatrist III, $700 to $860 mo., less maint.; Phychiatrist IV. $660-$980 mo., less maint. CONTACT: Paul Hletko, M.D., Chief Medical Officer, Department of Public Welfare, 160 No. LaSalle St., Chicago, Ill.

WANTED: Woman physician retiring from priv. pract. limited to diseases of women desires position in home or sanitarium for women. Lic. in Ill. Personal interview. Box 221, Ill. Med. Jl. 185 N. Wabash Chicago 1.

WANTED: Internist-Board Eligible, 29, avail. July 1955, family, group 4, desires ass'n with other internist or group. Prefers northern half of state, town 35,000 or more. Box 222, Ill. Med. Jl. 185 N. Wabash Ave., Chicago 1. 3/55

A BIG PROBLEM

The size of the accident prevention movement can be gauged by the fact that 13,000 representatives of industry and of local safety organizations gather in Chicago each year for a National Safety Congress. *Panel. Public Health Manpower to Meet Changing Health Needs. Pub. Health Rep., July* 1954.

‹ ›

The primary responsibility for the education of the patient (with tuberculosis) and the family rests with the physician making the diagnosis and with the physicians and nurses responsible for care. Mrs. K. Z. W. Whipple, NTA Bulletin, Feb., 1954.

What happens to salt?

The normal "renal threshold" value for sodium chloride is 560 to 570 mg. per 100 cc. of blood plasma. In the normal individual, as the plasma chloride concentration descends to this level, the elimination of chloride in the urine decreases and finally ceases entirely. Under normal conditions the quantity of chloride eliminated in the urine approximates the chloride intake; in cases in which there is marked variation in the quantity of chloride ingested it may require some time for an equilibrium to be established. For example, if the normal individual is kept upon an adequate sodium chloride intake (8-15 Gm.), the sudden addition of a large quantity of salt is usually followed by the complete elimination of the excess within forty-eight hours. However, if the individual has been maintained for prolonged periods of time on a low salt intake, the elimination of salt administered subsequently in large quantity my be delayed for several days, the body apparently retaining the added salt with greater tenacity. In conditions in which the elmination of chloride through other channels such as the skin (excessive perspiration) or gastrointestinal tract (vomiting or diarrhea) is increased, the urine chloride content is correspondingly diminished.—*Clinical Biochemistry, Abraham Cantarow, M.D. & Max Trumper, Ph.-D.) 3rd Ed. Revised); p.* 228.

THE KEELEY INSTITUTE
DWIGHT, ILLINOIS

Treating alcoholism and other problems of addiction.
REGISTERED BY THE AMERICAN MEDICAL ASSOCIATION—
MEMBER AMERICAN HOSPITAL ASSOCIATION.

Table of Contents

MARCH, 1955
Vol. 107, No. 3

YOUR ANNUAL MEETING—CHICAGO—MAY 17, 18, 19, 20

Editor
Harold M. Camp
Monmouth, Illinois

Associate Editor
Theodore Van Dellen
Chicago, Illinois

Business Manager and Managing Editor
Mr. L. E. Malley
185 N. Wabash Avenue
Chicago 1, Illinois

Business Office
185 N. Wabash Avenue
Chicago 1, Illinois

Editorial Office
Medical Arts Building
Monmouth, Illinois

Send original articles and membership correspondence to Harold M. Camp, Monmouth, Ill.

Send changes in the mailing list to Managing Editor, 185 N. Wabash Ave., Chicago 1, Ill.

Subscription price of this JOURNAL to persons not members of the Illinois State Medical Society is $4.00 per year, in advance, postage prepaid, for the United States, Cuba, Puerto Rico, Philippine Islands, Hawaiian Islands and Mexico. $5.00 per year for all foreign countries included in the postal union. Canada, $4.50. Single current copies 50 cents. By mail, 60 cents.

ORIGINAL ARTICLES

Epidemic Intelligence, Leonard M. Schuman, M.D., M.Sc., Minneapolis, Minn. 107
Ophthalmology in General Practice, Wm. Blender, M.D., Peoria .. 114
Cystic Fibrosis of the Pancreas Eccrinosis, B. M. Kagan, M.D., Chicago 120
Elective Induction of Labor, A Symposium, Robert N. Grier, M.D., Willard C. Scrivner, M.D., Edwin J. DeCosta, M.D., James E. Fitzgerald, M.D. 123
The Practice of Medicine in 1787, Lester S. King, M.D., Chicago .. 130
Diagnosis and Treatment of Thyroiditis, Adolph Kraft, M.D., and William Wolf, M.D., Chicago 136
Idiopathic Hypertrophic Pyloric Stenosis in an Elderly Adult, (Case Report) Harry W. Southwick, M.D., Danely P. Slaughter, M.D. and John A. Bollinger, M.D., Chicago 139
Fibrinolysis in Patients with Metastatic Carcinoma of the Prostate Gland, (Cook County Hospital Case Records) E. J. Dolaz, M.D., R. A. Dolehide, M.D. and I. A. Friedman, M.D., Chicago 142

EDITORIALS

Don't talk about the treatment 145
Research in gangrene 145
The 1955 Annual Meeting 146
The treatment of chronic leukemia 146
The death of Mrs. Andy Hall 147
Dinner meeting honors Roland R. Cross and state health department 147
Annual Meeting Illinois State Medical Society, Hotel Sherman, Chicago, May 17, 18, 19, 20, 1955 149
Book Reviews 62A

MEDICAL ECONOMICS

A Proposed Revision of the Coroner's Act of The State of Illinois, Edwin R. Hirsch, M.D., Chicago 152

THE P.R. PAGE 154

CORRESPONDENCE

Woman's Auxiliary plans for Annual Meeting 155
A course in the clinical pathology and pathology of parasitic diseases 155
General practice lectures 156
American Board of Obstetrics and Gynecology 156
Annual meeting of American Goiter Association 156
National Hospital Week 156
Clinics for crippled children listed for April 156
Annual Otolaryngologic Assembly 157
Prescription for medical partnerships 157
Fracture course 157

NEWS OF THE STATE 158

Entered as Second-Class Matter November 12, 1952 at the Post Office, Mendota, Illinois, under the Act of March 8, 1879. Acceptance for mailing at special rate postage provided for in section 1102, Act of October 8, 1917, authorized July 15, 1918. Printed monthly by The Wayside Press, Mendota, Illinois. Office of Publication, 1501 W. Washington Road, Mendota, Illinois. POSTMASTER — Return underliverable copies under form 3579 to 1501 W. Washington Road, Mendota, Illinois.

ACHROMYCIN CAPSULES

The most widely prescribed form
of this widely prescribed antibiotic.
ACHROMYCIN Capsules are available in potencies
of 50 mg., 100 mg., and 250 mg.

for every need—a suitable dosage form



AC

*REG. U. S. PAT. OFF.



BLUE

AT

BREAKFAST?

STOP morning sickness with BONADOXIN*

(BRAND OF MECLIZINE HCl, PYRIDOXINE HCl)

RESULTS of this new COMBINATION

In 50 patients with nausea and vomiting, Weinberg reports 88% good to excellent results.[1]

In another series, Bonadoxin abolished vomiting in 40 of 41 gravida, eliminated nausea in 30 of the 41.[2]

Each Bonadoxin tablet contains:

Meclizine HCl . . . . 25 mg.
Pyridoxine HCl . . . 50 mg.

Mild cases: One Bonadoxin tablet at bedtime.

Severe cases: One at bedtime and on arising.

In bottles of 25, prescription only.

1. Weinberg, Arthur, and Werner, W. E. E: Bonadoxin, a New Effective Oral Therapy for Hyperemesis Gravidarum, New York Medical College and Rockaway Beach Hospital, 1954.
2. Personal communication.

PFIZER Rx CHICAGO 11, ILLINOIS

*TRADEMARK

Schizophrenia and chlorpromazine

Schizophrenia, the most crippling and chronic of mental disorders, is the greatest challenge to psychiatric methods of treatment. About one-half of all schizophrenic patients were not substantially benefited by any combination of treatments hitherto available. In one series of 30 schizoprenic patients I reported, the situation two months after the conclusion of treatment (with chlorpromazine) was as follows: 8 were at home and symptom-free, 13 were much improved with most of them living at home, 5 were somewhat improved and 4 still no better. With so small a number of patients, conclusions must be limited. The results are highly provocative, however. It should be noted here that most patients on chlorpromazine are more accessible to psychotherapy; indeed, patients often discuss their deep-seated emotional problems spontaneously. *Vernon Kinross-Wright, M. D., Chlorpromazine-A Major Advance In Psychiatric Treatment. Postgrad Med. Oct. 1954.*

The epileptic considers marriage

Frequently you will be asked by patients or by their parents whether it is possible or advisable for them ever to marry and to have offspring. Obviously, if the patient with genetic epilepsy constitute only a small proportion of the total group, the problem of inheritance of seizures is far less serious than the inquiring individual would suspect. In those patients in whom genetic epilepsy is the undoubted diagnosis, the evidence now points to their being only one chance in 40 of an epileptic having an epileptic child. This incidence is approximately five times greater than the incidence in the general population. On the other hand, one can never assure a parent with acquired epilepsy that his or her children will not have epileptic seizures, but their chance of having them is no greater than in the general population. *William S. Fields, M. D. Practical Considerations in Treatment Of Epilepsy. Postgrad. Med. Oct. 1954.*

This drug has proved able
to control the disease
in two-thirds of patients
with ulcerative colitis,
who had previously failed to
respond to standard colitis
therapy currently in use*.



* See MORRISON: Rev. of Gastroent., Oct. 1953.

Azulfidine
BRAND OF SALICYLAZOSULFAPYRIDINE

PHARMACIA LABORATORIES, INC.
270 Park Avenue, New York 17, N. Y.



TRIPLE SULFAS

Meth-Dia-Mer Sulfonamides

SULFADIAZINE SULFAMETHAZINE SULFAMERAZINE

unexcelled among sulfa drugs

for highest potency • wide spectrum
highest blood & tissue levels* • safety
minimal side effects • economy

* Gram for gram, the Triple Sulfas produce and maintain higher blood and tissue levels with greater safety than any single sulfa. They are equally distinguished for their broad effectiveness and welcome economy.

These properties help explain why Triple Sulfas are by far the most widely used of all sulfas throughout the world, and why their use is increasing daily.

Triple Sulfas, alone or in combination with certain other agents, are available from leading pharmaceutical manufacturers under their own brand names. This message is presented in their behalf.

Cyanamid Fine Chemicals

Ask any medical representative about the Triple Sulfa products his company offers!

AMERICAN Cyanamid COMPANY, FINE CHEMICALS DIVISION, 30 ROCKEFELLER PLAZA, NEW YORK 20, N. Y.

Unwanted hair

Galvanic and faradic currents are among the most effective and least dangerous means of producing permanent epilation. A fine wire needle is introduced into the hair follicle, to a level as close to the hair bulb, or growing point, as possible. The current is turned on and in a few seconds, the hair bulb is destroyed and the hair can be removed without resistance. If done properly, there are no scarring results. A slight, variable pain is produced momentarily. Only occasionally is pain of sufficient degree to preclude the use of this modality. Regrowth will not occur if the current is of sufficient length and intensity and is applied properly to the region of the growing point of the hair. If it is not done properly, the hair will regrow. Even when done by experts, 10 to 25 per cent of hairs will regrow. Most physicians cannot use this method on more than 25 to 35 hairs at one sitting because of the fatigue of the eye and hand of the operator. When one considers that there are roughly 12,000 to 15,000 hairs on the face, it can be easily understood why this procedure is not economically feasible for the average patient unless the numbers of hairs involved are relatively small. The method is ordinarily restricted to the faster growing, thick, black hairs that are most noticeable. *Herbert G. Mescon, M.D., et al. Hypertrichosis. Boston Med. Quar., Sept.* 1954.

‹ ›

Regional ileitis

Regional ileitis is a clearcut concept: a disease of young people. The average age is about 25 to 27; males are affected somewhat more than females. The youngest case I have seen was 9 months of age, confirmed by an exploratory laparotomy. The oldest case I remember was 71 years of age, although recently in the office we encountered a case in the late sixties and were interested to note that this case of regional ileitis apparently has its onset in the later decades of life. *Burrill B. Crohn, M.D., Regional Enteritis. Maryland M. J., Oct. 1954.*

Lederle

GRAVIDOX*

Pyridoxine-Thiamine *Lederle*

For preventing and treating nausea and vomiting of pregnancy

Pyridoxine (B_6) and Thiamine (B_1) have proved more effective in combination than either alone in the prevention and treatment of hyperemesis gravidarum. GRAVIDOX, in tablet and parenteral form, combines these vitamins, providing a nutritional approach to the problem. GRAVIDOX may also be useful for the prevention and relief of nausea and vomiting associated with radiation sickness.

Each GRAVIDOX tablet contains: Thiamine HCl—20 mg., Pyridoxine HCl—20 mg. Each cc. of GRAVIDOX parenteral solution contains: Thiamine HCl—50 mg., Pyridoxine HCl—50 mg.

Average dose: 5 to 12 tablets daily, in divided doses, at times when vomiting is less likely to occur; or 1 cc. parenteral solution 2 or 3 times weekly.

LEDERLE LABORATORIES DIVISION AMERICAN Cyanamid COMPANY Pearl River, New York

*REG. U. S. PAT. OFF.

The
ILLINOIS
Medical Journal



Official Journal of The Illinois State Medical Society

MARCH 1955
VOL. 107 NO. 3

Epidemic Intelligence

Leonard M. Schuman, M.D., M.Sc.* Springfield
Deputy Director, Division of Preventive Medicine, Illinois Department of Public Health

EXACTLY one year ago, in this very meeting place, Perrin Long[1] presented a brilliant analysis of the impact which the decline of certain of the infectious diseases has had upon present day health status and practices. Utilizing mortality rates, he demonstrated downward trends for several ancient causes of death and was satisfied that the control of infectious disease by public health methods and improved environmental conditions contributed in no small way to these declines. Improved techniques of diagnosis in the clinical and laboratory field and the advent of specific serotherapy, chemotherapy and antibiotics certainly influenced the trends in mortality in a major way. It is a common and necessary device to draw attention to such spectacular gains in the reduction of mortality if only to lead the medical sciences to an interest in the new and increasing hazards to the life of man. The aging population and its accompanying hazards, both physical and mental, present problems begging for solution and the magnitude of these problems fully justify a concerted approach for their solution.

However, mortality trends may be deceiving and the pride we manifest in our spectacular gains in the communicable disease field is actually leading to an insidious apathy which has its roots in a satisfied complacency. We are impressed with drastic reductions in the decline of mortality and even morbidity from such diseases as diphtheria, scarlet fever, tuberculosis, typhoid fever and smallpox and we all too glibly overlook several features of the natural history and characteristics of certain of these diseases. First and foremost is the well known observation that prevention of mortality does not necessarily go hand in hand with the prevention of morbidity. Measles is the classic example for, whereas mortality has been reduced by passive prophylaxis with gamma globulin and treatment of the complications, morbidity has continued unabated. Furthermore, hidden in a statement by Long[1] on the amount of reduction in incidence of diphtheria which may have been produced by immunization, is the well accepted theory among epidemiologists of the secular cyclicity of many of the pandemic diseases.

Presented at the 114th Annual Meeting of the Illinois State Medical Society, Chicago, Illinois—May 20, 1954.

**Now Professor of Epidemiology, University of Minnesota Medical School, Minneapolis, Minn.*

Diphtheria incidence reached its world-wide peak in the period 1860-90 and had declined by more than 90% before the introduction of active agents of immunization[2]. The practical answer to this particular dilemma is obvious. We must continue to tamper with nature by maintaining the active immunity of our populations so as to offset potential reversals of the cycle regardless of whether such cyclic upswings are due to increased pathogenicity, dispersibility or invasiveness of the diphtheria bacillus. And yet, in recent surveys[3] of immunization status among 92 counties in Illinois, only 36 counties had an average of 70% or more school-age children vaccinated for smallpox and only 39 counties with 70% or more immunized against diphtheria.

In 1950 at a National Morbidity Reporting Conference sponsored by the U. S. Public Health Service, there were a few participants who felt that the streptococcal infections could be dismissed summarily on the grounds that the increasingly wide use of antibiotics and chemotherapeutic agents, judiciously or otherwise, would eventually wipe out the entire race of streptococci! Little did they realize that that very year, 1950, marked the turning point in the previously declining incidence of such infections, so that an upswing became apparent. Figure 1 reveals the trend of the Illinois experience from 1941 to the present time. (Your attention is directed to the necessarily different scales for scarlet fever as opposed to septic sore throat and acute rheumatic fever.) Attention is called to the provocative parellelism between the incidence trends of scarlet fever and septic sore throat on the one hand and that of rheumatic fever on the other, despite the continued mild character of the streptococcal infections. It is impossible to predict whether such infections may reach the proportions experienced at the turn of the century for it is difficult to separate the fractional incidences due to unsanitized milk supplies in the past from those due to person-to-person contact which certainly has continued to the present time.

A second characeristic of the natural history of epidemics is the rather impressive, if not startling, observation that certain etiologically undefined diseases, such as the "sweating sickness" of Europe, disappeared completely before

FIG. 1

SCARLET FEVER, SEPTIC SORE THROAT
AND RHEUMATIC FEVER
ILLINOIS 1941-1953

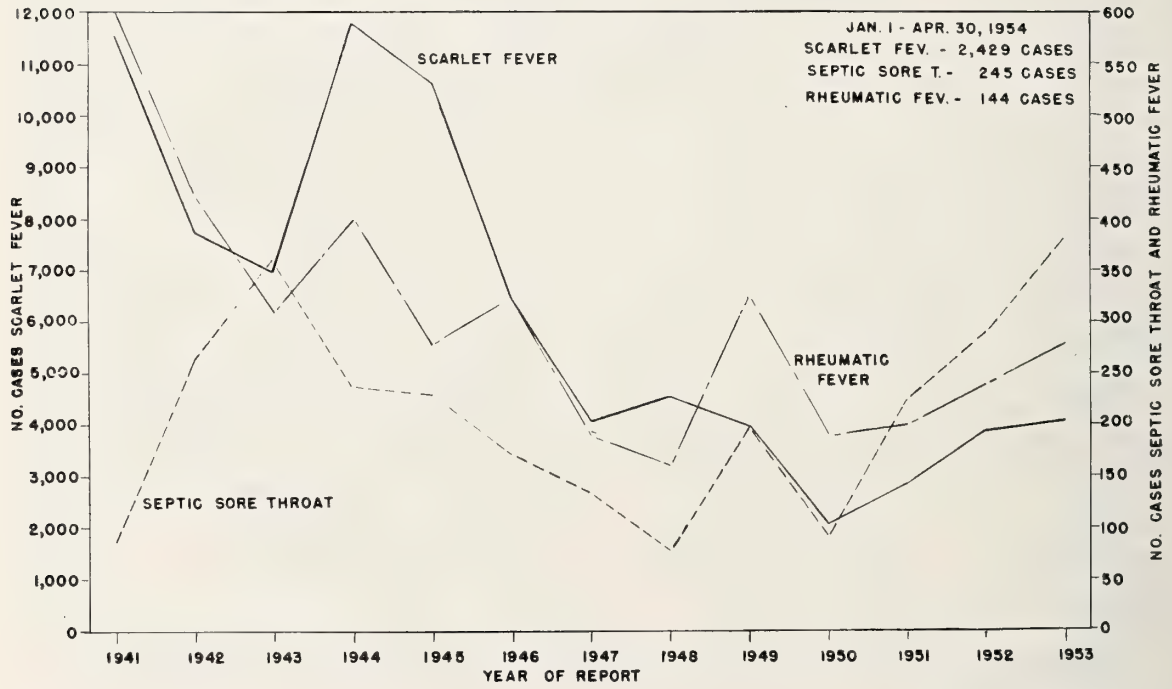


FIG. 2

POLIOMYELITIS IN ILLINOIS
1938 - 1953



definition could be attempted and other more modern epidemics such as poliomyelitis, infectious hepatitis and encephalitis, to name but a few, have appeared on the scene.

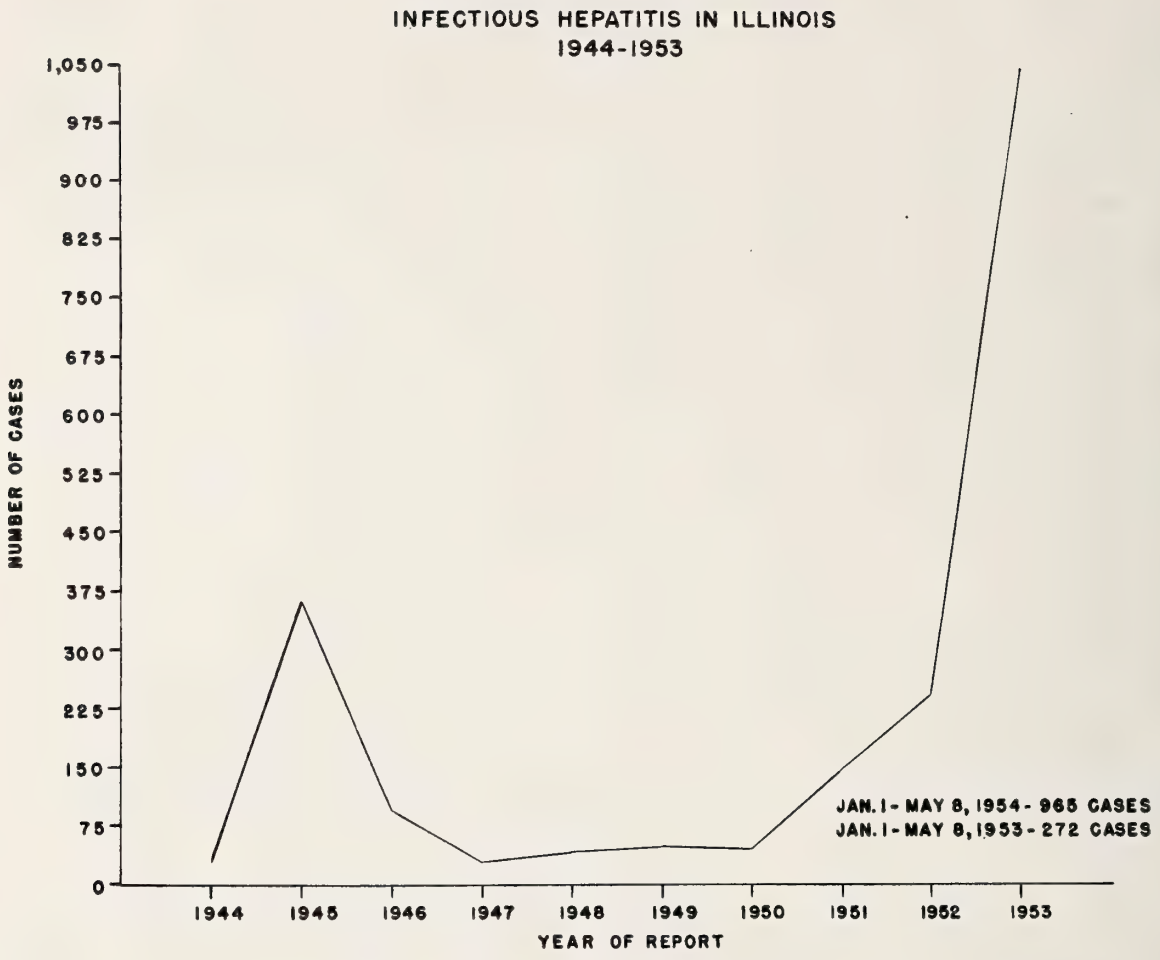
In Illinois since 1938 there has interjected itself an ever increasing incidence of poliomyelitis. Figure 2 presents the reported incidence of poliomyelitis in Illinois. It will be noted that despite a three-year cycle, the trend is continuously upward. This same pattern is true for the nation as a whole and cannot be dismissed by the fact that the diagnosis of non-paralytic poliomyelitis has vastly improved, for the incidence of paralytic cases has increased proportionately. Of interest are relatively recent observations indicating a diminution of early subclinical infection with polio virus, and thus less rapidly developing immunity, as the sanitary environment has improved.

Figure 3, representing the reported incidence of infectious hepatitis in Illinois, also reflects the trend presently being experienced throughout the country. 1953 saw a four-fold increase in reports over 1952 and thus far in 1954 there has been a four-fold increase over the corresponding period in 1953. It might be argued that awareness and recognition of anicteric cases have contributed to this upsurge. However, spot surveys in Illinois in 1953 have revealed that physicians actually had not seen the disease in such numbers before and analysis of gamma globulin distribution data reveals that in 1953 only 25% of the physicians reporting infectious hepatitis requested gamma globulin for contact prophylaxis. Thus, availability of gamma globulin for such use could not be responsible for a four-fold increase in reporting in 1953 as compared to 1952. This information begs the conclusion that a continuing true rise in incidence is occurring.

Dorland Davis[4] has indicated that the appearance of such epidemics "suggests that there is a changing pattern in causation of epidemics and one can speculate that a whole new experience with infectious agents may be in store for us."

What, then, can we as physicians and health

FIG. 3



officers do about present and future control? First, we must recognize the fact that, although some of our energies must of necessity be diverted to the chronic diseases, we dare not sell the infectious diseases short. Even if we accept the decline of certain of these diseases with the perfectly human sense of pride in accomplishment, we cannot afford to overlook the obviously evolving problems of the relatively newer diseases. Secondly, we must recognize that, whereas official health agencies have the legal responsibility for control of these diseases, we, as physicians, have the moral responsibilty of contributing to area-wide awareness of the problems by adequate reporting. No disease has ever been controlled without knowledge of the intensity of its occurrence, the time of its occurrence and its location, followed by analysis of its interaction with host and environmental factors — in brief, epidemic intelligence.

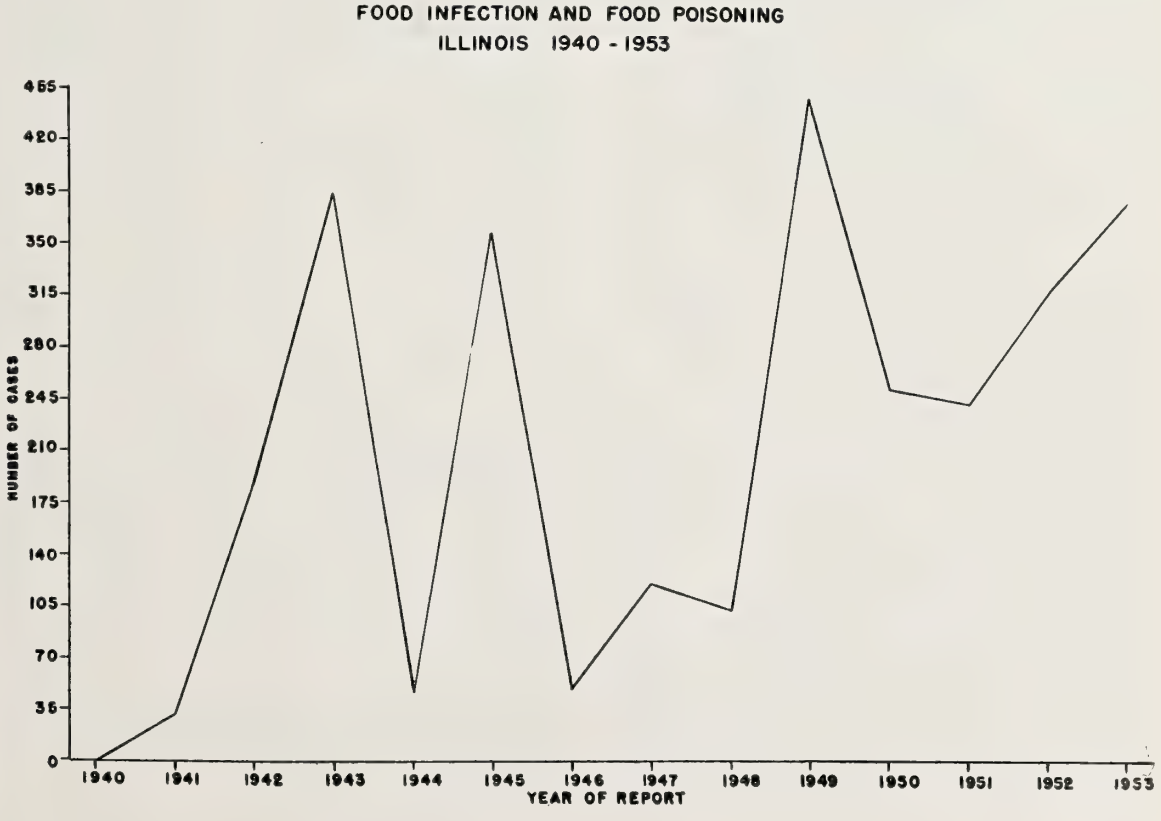
Furthermore, no individual physician can alone be aware of the totality of the community's problem but he certainly can obtain the picture at a moment's notice from his health department, which can be looked upon as the sensitive control center receiving data for correlation from all physicians in the community and assisting in the suppression of outbreaks. A corollary to this is that a single physician does not have the whole outbreak or recrudescence of disease in his own practice (unless he is a lone practitioner in an isolated rural area) and if he is interested in the health of his community he cannot obtain the complete picture from his health department unless he and all his colleagues report all acute morbidity.

The mainstay of epidemic intelligence is, then, official morbidity reporting, but even this well-established system has its serious shortcomings for it is first and foremost based upon definitive

diagnoses. Frequently a time lag in such diagnosis is unavoidable and early reporting and institution of control procedures is delayed. Furthermore, many entities, such as the upper respiratory infections — influenza and the common cold — with common symptoms, lack simple rapid laboratory tests making definitive diagnosis difficult and so remain unreported. Many infectious gastrointestinal entities, readily definable by simple laboratory examination of stools, are not subjected to such laboratory scrutiny, remain etiologically unknown and hence unreported and uncontrolled despite high and prolonged community morbidity. All too frequently laboratory examination is not attempted since the illness in the individual case may be moderate or mild and of short duration but nonetheless may spread surely and rapidly through a population group. The salmonelloses and shigelloses are notorious in this respect.

In Figure 4 the recent record of reported food infection and poisoning in Illinois is portrayed. From inquiries by health officers of several areas in the presently rudimentary attempts at setting up a system of epidemic intelligence, it became apparent that these morbidity data are grossly deficient. In fact, the graph is presented as a consolidated experience without reference to etiologic agent for only in the last 2 or 3 years have there been signs of increasing attention to definitive laboratory diagnosis in this group of diseases. In 1953, of 377 cases reported, 216 were attributed to Salmonella, 4 to Botulinus toxin, 153 to Staphylococcus toxin and the remaining 4 reported as either food infection or poisoning without etiologic reference. Of the salmonellosis cases, 75 were involved in 9 outbreaks and 141 were supposedly single cases. Although shigelloses is not customarily classed with food infections or poisonings, it is of interest that of 170 cases reprted in 1953, 99 were in 8 outbreaks, one of which, representing 70 cases, occurred as a food-borne infection. Though a good start has been made, it is obvious that the bulk of the reporting was initiated either by laboratory examination or because of an explosive outbreak. The unknown hundreds or possibly thousands of cases of acute gastro-enteritis inferred by spot checks throughout the state failed to be reported since a simple stool examination,

FIG. 4



available at all the State laboratories, was not performed.

Nor do the official data represent any cases of acute infectious nonbacterial gastro-enteritis which all too frequently are lumped into the scientifically unjustified phrase of "intestinal flu", unjustified for they are not at all related to the established entity, influenza. Cooperative studies between physicians and health agencies have recently isolated two antigenically distinct viruses producing two distinct clinical pictures of gastro-enteritis in outbreaks in New York and Ohio,[5,6] which leads us to the final but probably most important shortcoming of present day morbidity reporting systems. Since the profession has been conditioned to reporting of etiologically defined entities, a barrier is immediately set up for those entities for which no definable agent can presently be incriminated. In such ill-defined entities which at times may represent the vast bulk of morbidity in a community, there is a need to clarify their modes of attack on the population, their modes of occurrence and their relationship to similar but well-defined diseases. There is a basic need for uniform clinical description, understanding of incidence patterns, mode of transmission and the search for the agent toward the end that control of the disease may be established.

Epidemic intelligence must, therefore, be redefined as an awareness of total acute illness in the community and not confined to the readily definable diseases. Regardless of whether prophylactic measures are available, such total awareness is necessary for the development of controls. The course of action, then, is clear. Most of the shortcomings of present day morbidity reporting may readily be overcome by increased use of available laboratory aids in the diagnosis of definable entities. Ill-defined entities or those for which no agent has thus far been demonstrated can be reported to the health officer by predominant symptom or sign or, as a symptom-complex becomes apparent, by such constellations of signs. The health department, in turn, could thus give valuable assistance to the physician and community by executing epidemiologic investigations in the field, which will contribute toward an understanding of the natural history of the disease entitiy, its relationship to the environment and add vital data ultimately necessary for the development of sound control programs. This service does not end here, for health department laboratory facilities may assist the physician in ultimately defining the entity etiologically. A recent experience in northwestern Illinois in which physicians and health officers cooperated has led to a significant advance in the knowledge of non-psittacine ornithosis. Clinical, epidemiologic and laboratory talents were combined in a study of approximately 70 cases of relatively prolonged respiratory illness suggestive of, but not similar to psittacosis. The majority of the cases were rural residents whose only contact with avian species was the raising of chickens. In both man and birds significant titers to the psittacosis-lymphogranuloma venereum group were demonstrated by Ward, Hildinger, Birge and Morrissey.[7] Their findings have been submitted for publication to the Journal of the American Medical Association.*

Nor does the yield of physician-health officer cooperation in epidemic intelligence accrue to the individual community alone. Reports transmitted by local health departments are digested and broadcast to all official health agencies in the State and to the U. S. Public Health Service for nationwide dissemination. Thus health agencies alert physicians to new epidemic symptom-complexes throughout the country, perform field investigations, add to the data so that analyses may be made and thus contribute to the synthesis of a defined entity. Widely dispersed outbreaks of similar complexes, each lacking some vital data, may reinforce each other, so that a clear understanding of the disease ensues. The rapidity of spread of such epidemics or outbreaks, no matter how small, may also be judged so that distant communities in the apparent path of the disease may be alerted. The spread of epidemic keratoconjunctivitis from the Western Seaboard eastward during World War II is an impressive example. The impact of epidemic intelligence systems on community alertness to bacteriologic warfare needs no elaboration in these days of continuous international emergency.

Even the individual bizarre or rare case in a community may have profound significance in

* Since reported: J.A.M.A. July 24, 1954, Vol. 155 p. 1146

the development of new epidemiologic knowledge of disease and no physician needs ever to minimize the size of his contribution to such knowledge by the reporting of a single case. In a joint study of sarcoidosis by the Veterans' Administration and the U. S. Public Health Service among discharged military personnel, there was found an intriguing geographic relationship among the cases. A highly significant number were born and raised and maintained their residence in communities along the granitic shield of the eastern slope of the Appaalachians. Studies of soil from their widely dispersed yards revealed the same geologic origin. The systemic character of the disease, its similiarity to the infectious process and a suggested possibility of certain specific fungi (possibly found only in such soils) as the etiologic agent make this epidemiologic investigation intriguing. Thus, to the physician, the existence of a single case in the entire community may not appear pertinent to a system of epidemic intelligence but his contribution by reporting such single cases can bolster the framework of a theory or prove the existence of a principle.

Finally for those diseases for which low residual levels have been reached, as diphtheria, malaria and smallpox, surveillance of individual cases or suspect cases becomes necessary so that we may guard against their recrudescence or importation. Interstate quarantine regulations do not retard the free movement of susceptible individuals from area to area or into endemic regions, nor should such restrictive regulations be imposed. Surveillance, which implies prompt recognition or suspicion, reporting and immediate field investigation, plus the maintenance of high immunity levels may be adequate as a safeguard. Thus, reporting of the individual, etiologically-defined case also has a prominent role in epidemic intelligence.

In conclusion, it can be said with utmost sincerity that the practicing physician and the health officer are mutual partners in epidemic intelligence systems, but the practicing physician remains the keystone of the arch between the individual and the community's health.

BIBLIOGRAPHY

1. Long, P. H.: The Social and Economic Impact on Medicine of the Control of Infectious Diseases. Ill. Med. J. **104**, 349 (Dec.) 1953.
2. Schuman, L. M. and Doull, J. A.: Diphtheria Infection and Morbidity in Cleveland, 1937-1939. Am. J. Pub. Health, Supplement **30**, 16 (March) 1940.
3. Schuman, L. M. and Church, R. E.: Unpublished data of the Illinois Department of Public Health.
4. Davis, D. J.: Epidemiology in National Emergency. The Military Surgeon, **114**, 356 (May) 1954.
5. Gordon, I., Ingraham, M.S., and Korns, R. F.: Transmission of Epidemic Gastroenteritis to Human Volunteers by Oral Administration of Fecal Filtrates. J. Exp. Med. **86**, 409 (Nov. 1) 1947.
6. Jordan, W. S., Jr., Gordon, I., and Dorrance, W. R.: A Study of Illness in a Group of Cleveland Families: VII. Transmission of Acute Non-Bacterial Gastroenteritis to Volunteers: Evidence for Two Different Etiologic Agents. J. Exp. Med. **98**, 461 (Nov.) 1953.
7. Ward, C. G., Hildinger, A. L., Birge, J. P., and Morrissey, R. A.: Respiratory Disease Associated with Significant Serologic Titers for the Psittacosis-Lymphogranuloma Venereum Group. Submitted for publication to J.A.M.A.

‹‹‹ ›››

Referred from the nasopharynx

Infection of the nasopharynx gives rise to more complications than involvement of any part of the upper respiratory tract. It is one of the most difficult problems for the general practitioner to treat. Infection here can cause pain in the mastoid area by irritating the vidian and petrosal nerves. It can cause pain almost anywhere in the face by irritating the fifth nerve through the sphenopalatine ganglion, and also cause pain in the throat, coughing, and dysphasia by irritating the ninth cranial nerve. Most cases of chronic progressive deafness and otitis media, as well as persistent low grade fevers, arise from involvement of this area. Infection of the nasopharynx and the pharyngeal walls associated with a postnasal discharge, often is the causative factor in prolonged unproductive cough and in recurrent or chronic bronchitis. *Benjamin S. Rich, M.D., Otolaryngology in General Practice. Maryland M.J., Oct. 1954.*

OPHTHALMOLOGY

In General Practice

Wm. Blender, M.D., Peoria

IT is generally conceded by most medical educators that practical instruction in the specialities of medicine is practically non-existent in the present medical school. In turn, there has been a definite trend toward greater emphasis on the importance of the general practice of medicine. I heartily agree with this new attitude toward the general practitioner, but, in some instances, it has resulted in the acquiring of a false sense of ability to care for some serious conditions encountered in ophthalmology. All busy general practitioners see numerous, varied ocular cases in their offices. Therefore, the general practitioner should be able to diagnose and care for the ocular conditions that are properly considered to be within the field of general practice. The family doctor should be able to make an accurate differential diagnosis of simple conjunctivitis, iritis, glaucoma, and corneal disease. He should be familiar with the technique of removal of a foreign body from the cornea, its after care, and the legal responsibility of such a case. He should, also, have a working knowledge of the various ocular therapeutic agents. He should be able to give the consulting patient pertinent advice about various ocular conditions. With the foregoing remarks in mind, I shall discuss some ocular conditions most commonly encountered in the general practitioner's office.

EQUIPMENT AND MEDICATIONS

To practice good ocular medicine, it is essential that you have a minimum of equipment and ophthalmic medications in your office. A Snellen chart, and a twenty foot lane is necessary. A good loupe, such as a Magni-Focuser, is invaluable for removing foreign bodies. This instrument will give you two and one half times magnification at a good working distance, and will permit you to effectively use both of your hands. The solutions available should include the following:

Pontocaine ½%
Scopolamine 1/5%
Homatropine 2½%
Phenylephrine hydrochloride (Neo-synephrine) 2½% and 10%
Pilocarpine 2%
Fluorescein 2%
Atropine 1%

Fluorescein 2% solution should be made up as follows:

Sodium bicarbonate gr vx
Fluorescein gr x
Water qs ad oz i

Zephiran 1:3500 is a good vehicle for the Pontocaine, atropine derivatives, and pilocarpine. It will keep your solutions sterile, and by its wetting action promote absorption. Scopolamine and homatropine are cycloplegic drugs. They paralyze the ciliary body. Neo synephrine is a mydriatic drug, and it will produce dilatation of the pupil without affecting the ciliary body and accommodation. This type of drug is indicated when you desire dilatation for ophthalmoscopy. Pilocarpine is a miotic drug which constricts the pupil. It should be instilled in the eye after you use a drug that dilates the pupil, especially in the patient after forty years of age.

FOREIGN BODIES OF THE CORNEA

Before accepting the care of an ocular foreign body case, by all means, for medical-legal reasons record an accurate history and visual acuity. Always evert the upper lid to rule out a foreign body trapped under the upper lid. Look carefully for an inturned lash rubbing on the cornea. The surface of the cornea should be examined carefully, instructing the patient to look in different directions. This procedure, many times, will help you find a small corneal foreign body that blends with the iris. One half per cent Pontocaine is the best local anesthetic for the eye. Use two

or three drops at two minute intervals for complete anesthesia. One of the best instruments for removal of corneal foreign bodies is a sharp pointed Bard-Parker knife, and with your loupe, good intense light, and this instrument, you can successfully remove most superficial corneal foreign bodies. I do not believe a cotton applicator is an acceptable means to remove a corneal foreign body. It is possible only to remove the most superficial foreign body, and it is inevitable that you will abrade the cornea extensively. If, after you remove a metallic foreign body, and see a rust ring, it is advisable that you refer this case to an ophthalmologist. This rust ring should be removed under a corneal miscroscope as it will delay healing, and could initiate corneal ulceration. The after care of a corneal foreign body is the prescription of an eye ointment, such as five per cent sulfadiazine, or a solution of sulfacetamide fifteen to thirty per cent. Do not dress the eye or prescribe any local anesthetic as this will delay healing. In fact, never prescribe a local anesthetic, as Pontocaine or Butyn, for indiscriminate use for this same reason. You should see this case every day or two until healed, and the last visit again record the visual acuity.

CORNEAL ABRASIONS

Corneal abrasions are a common occurrence, and they require prompt correct treatment. The patient will present the usual symptoms of corneal injury, namely, photophobia, pain, and lacrimation. Anesthetize the eye with Pontocaine and stain it with fluorescein. Put one drop of fluorescein in the eye and wash it out gently with normal saline. The abraded area will be outlined as a bright green area. If the abrasion is extensive, the only effective treatment is cycloplegia and a pressure dressing. A word of caution about the use of cycloplegic drugs. They are used to paralyze the ciliary body and create a quiet eye, which in turn will reduce pain and promote healing. I do not believe a general practitioner should ever use atropine except in children. Its effect is prolonged, and by its depression of accommodation, will cause much disability. You should never use a cycloplegic drug in the older group of patients past forty years of age, because of the danger of precipitating an attack of acute glaucoma. Always palpate the globe with your two index fingers, and if it feels unusually firm, never use a cycloplegic drug. Scopolamine 1/5%, and homatropine 2½%, are good cycloplegic drugs as their action is only for one to three days, and yet they will relax the ciliary body enough to give you the desired effect. After deciding if cycloplegia is advisable, instill the drug as a drop or ointment. Mold moist cotton over the eye, and next place over the closed lids several eye pads, or a comparable amount of gauze. Next firmly place one half inch adhesive strips parallel, and overlapping each other, from the brow to the cheek. Place these strips firmly in place so it will be impossible for the patient to move the underlying lids. This dressing is removed in 24 hours, and reapplied if the eye stains. This is the only effective method to stop pain and to promote healing of a corneal abrasion.

PENETRATING INJURIES OF THE GLOBE

Ocular injuries of a penetrating type require special consideration. If you have reason to believe there has been a penetrating injury, or if there is a prolapse of some of the internal structure of the eye, it is advisable not to instill any medication. A light sterile dressing may be applied without any pressure on the globe. Also, instruct the patient not to increase the intraocular pressure by lowering the head, or touching the globe in anyway. This type of case should be referred as soon as possible.

LACERATIONS OF THE LID

Lacerations of the lid are not uncommon. If the laceration extends entirely through the lid from the skin to the palpebral conjunctiva, each tissue layer should be sutured separately. The conjunctival layer should be closed first with a plain continuous fine catgut. The tarsus can be closed with a fine, mild chromic continuous catgut suture. The skin is closed with interrupted 6-0 black silk suture beginning away from the lid margin. The last suture at the lid margin should exactly unite the edges of the lid at the white line. This is a landmark between the skin and conjunctiva at the edge of the lid. This will prevent notching, and deformity of the lid margin. If the laceration is at the medial part of the lid, always consider the possibility of the lacrimal puncta and canal involvement. This type of injury will require special reconstructive repair.

STRABISMUS

Every ophthalmologist sees cases of strabis-

mus that have been advised by their family doctor to wait a certain specified time before seeking ocular advice and treatment. It is conceded now that ocular movements are binocular after the age of six months, and any deviation after this age is pathological. Any obstacle to binocular vision is the only etiological factor of a strabismus case. I shall mention only a few of these many and varied binocular obstacles, such as errors of refraction, intraocular tumors, opacities in the lens, media or cornea, retinal disease, anomalies and injuries of the extra-ocular muscles, orbital disease, pathology in the motor nerve trunk, nuclei, and higher centers. It should now be obvious that immediate examination is imperative in every strabismus case, after the age of six months.

A word about the diagnosis of pseudo-strabismus in children. Do not become discredited by diagnosing strabismus in this situation. Several peculiarities of the orbit, globe, and eye lid may simulate strabismus. In many infants a congenital vertical fold of skin at either side of the nose will cover the medial sclera, and an illusion is created that the eye is turned inward. Also, a narrow inter-pupillary distance will simulate convergent strabismus, and conversely, a wide inter-pupillary distance will simulate divergent strabismus. If you will utilize the simple practical diagnostic procedures described below, you should never be confused by a pseudo-strabismus case.

The easiest is the corneal reflex test. Shine a light toward the patient's nose and note the position of the light reflex on the cornea. In a convergent case, the light reflex in the deviating eye will be displaced in an opposite direction. The opposite will be true in a divergent case. The monocular cover test is another good diagnostic procedure. A cover is placed over one eye and simultaneously the behavior of the other eye is observed. Any movement, inward or outward, indicates a strabismus is present. The position of the head should be noted. A head tilt usually indicates a vertical deviation is present.

With this background, and I repeat, all strabismus cases from six months and on, should be examined immediately to determine the exact obstacle to binocular function. Early observation and treatment are also essential to prevent loss of vision from disuse of the deviating eye, and to re-establish the complex mechanism of binocularity.

EPIPHORA IN NEWBORNS

The nasolacrimal duct opens in to the nose in the inferior meatus, below the inferior turbinate bone. Before birth, this opening is still closed by mucous membrane. This should disappear shortly before birth, but in some cases this is delayed. Tears begin to be formed about three weeks after birth, so if an obstruction is present the epiphora will become evident to the mother, and she will seek your help. I believe these cases should be treated conservatively as long as possible. The eye sac may be irrigated with normal saline when necessary. It is also advisable to prescribe a suitable antibiotic eye drop. The mother can be instructed to massage the lacrimal sac down and in towards the nose. The majority of these cases will clear up spontaneously in two to three months. This is the best argument for conservatism. If this does not occur, then probing and irrigation are indicated.

GLAUCOMA

All general practitioners should be glaucoma conscious. It has been estimated that this disease causes 12% of all of the cases of blindness in the United States. Glaucoma may be defined as an abnormal elevation of intraocular pressure. Vision is lost because of permanent damage by this abnormal pressure to the nerve fibers entering the optic disc. Clinically you should be able to recognize two types of primary glaucoma.

The acute congestive type is found in people that have narrow anterior chambers and narrow angles at the root of the iris and cornea-scleral junction. In observation with the naked eye, if the anterior chamber is extremely narrow, the iris will appear as being almost in apposition with the posterior surface of the cornea. Most of these eyes are smaller than normal. Prodromal symptoms which should make you suspicious of this type of case are episodes of haloes and sudden attacks of globe pain of a varying degree.

An acute attack of congestive glaucoma is an ocular tragedy. The onset is sudden, and it usually follows an emotional upset, or similar situations which would cause a dilatation of the pupil. This will crowd the narrow angle with iris tissue, which will prevent the normal drainage of the intraocular fluid. The eye will suddenly become congested. The pupil will be dilated, irregular and immobile. If the tension is very high, the

cornea may become steamy. Upon finger palpation, the globe will feel stony hard. The subjective symptoms will be intense. The pain is extreme, and it may be centered in the globe or about the orbit. Nausea and vomiting are common.

The second type of primary glaucoma is the open angle type, or chronic simple glaucoma. In this type there is no predisposing anatomical factor, and the exact etiological basis is obscure. The course and symptoms are insidious; consequently, it is difficult to diagnose in the early stages. Frequently there will be no subjective symptoms whatsoever. There may be some vague headaches. Sometimes the patient will complain of mild globe tenderness or aching, especially in the morning when the tension will be the highest during the 24 hours. A frequent change of glasses is a suspicious sign in early presbyopia. Actual loss of vision is a late complaint, and means that the disease is far advanced.

Other types of glaucoma we recognize clinically are secondary glaucoma and congenital glaucoma. As the word implies, secondary glaucoma is caused by and follows other ocular disease and conditions as iritis, swollen and dislocated lenses, and many other types of ocular pathology. The treatment is directed towards the causative factor. Congenital glaucoma is caused by a faulty development of the drainage angle of the eye. This condition will appear early in life and these infants will have large ox-like eyes. The treatment is miotic therapy and surgery of the maldeveloped angle.

The ophthalmologist treats primary glaucoma with drugs that constrict the pupil. In some cases surgery is indicated, but regardless of the type of case with which we are confronted, early recognition and treatment are essential for prevention of loss of vision. At the best, whether medical or surgical, the treatment leaves much to be desired, especially if this treatment is instituted late in the course of the disease. I feel that the field of general practice is a fertile place to first recognize many new cases of glaucoma, especially if the general practitioner is alert and thinks of glaucoma. Very little can be done for the case of glaucoma that has progressed unrecognized, and the vision lost before treatment has begun is never recovered. Therefore, again, be glaucoma conscious and be extremely cautious in the use of any drug that dilates the pupil in the older age group of patients.

CONJUNCTIVITIS

Acute inflammation of the conjunctival sac is one of the most common ocular condition that the family doctor sees in his office. Certainly conjunctivitis is rightfully within the field of the general practitioner, but it is unfortunate that the red eye of an acute conjunctivitis may simulate many serious ocular diseases. Consequently, an exact differential diagnosis is in order. Before accepting and treating this type of case, by all means, rule out the more serious types of ocular disease as iritis, glaucoma, and corneal disease.

On the first visit, if possible, you should make a smear or a conjunctival scraping. Many cases will have a discharge early, but when no discharge is available, the conjunctiva should be scraped with the edge of a scalpel. This will enable you to obtain material to effect an early diagnosis as in a case of Gonococcal infection where the bacteria are deep in the superficial cell layers during the first 24 to 48 hours. The smears are best stained with Grams stain or methylene blue stain. The scrapings can be stained with one of your blood stains as Wrights or Giemsas stains. These simple procedures will give you a definite clue as to the presence of gram negative or gram positive organisms and the morphology of the organism.

The clinical examination may help you confirm your bacteriological diagnosis. In some cases the clinical signs suggest the correct diagnosis. A thin mucoid discharge indicates a mild catarrhal type of inflammation. A heavy purulent discharge immediately suggests a pyogenic infection. The conjunctiva in a bacterial inflammation is reddish, and in an allergic conjunctivitis is pale and milky appearing. Chemosis in an acutely inflamed eye suggests a gonococcal infection or a hyperacute bacterial infection. Chemosis in a white eye may suggest trichnosis. Enlargement of the pre-auricular node suggests a viral infection or a granulomatous conjunctivitis. Ulcerations of the conjunctiva are common in tuberculous infections of the eye sac. Membranes are seen in infections of either C. diphtheriae and S. hemolyticus. Occasionally membranes are seen in acute pemphigus and erythema multiforme.

Thin membranes are present in vernal catarrh. Blepharitis, especially in the presence of a mild conjunctivitis, suggests a Staphylcoccic infection.

DIFFERENTIAL DIAGNOSIS

Corneal disease and serious intraocular disease frequently will simulate acute conjunctivitis. Always suspect corneal disease when there are signs of involvement of the ophthalmic division of the fifth cranial nerve. This is characterized by photophobia, lacrimation, and pain. The pain will be aggravated by movement of the lids, and the patient may complain of a foreign body sensation. Circumcorneal, or ciliary congestion, may be present. Careful examination using a stain may reveal an ulceration or other corneal involvement.

Inflammation of the internal pigment tissue of the inner eye as iritis will be characterized by severe objective and subjective symptoms. The pain will be centered in the eye or in the distribution of the first branch of the fifth cranial nerve. There is marked tenderness of the globe. You should note the ciliary injection at the cornea-scleral junction. The pupil will be small and spastic. Occasionally the pupil may be irregular, if the case is late.

I have previously described the striking symptoms of acute glaucoma. The differential diagnosis of acute iritis and acute glaucoma at times may be difficult, but this is not a problem for the general practitioner.

An acute conjunctivitis case has mild subjective symptoms. The patient will complain of a grittiness or burning. There should be no pain of any marked degree. The lids will be sealed in the morning from the accumulation of the discharge during the night. The hyperemia will be more evident on the palpebral surface of the conjunctiva. There will be some swelling of the lids and conjunctiva. The pupil will be normal and it will react normally to light. Ciliary congestion is not present in this type of case. Corneal and intraocular disease is diagnosed more frequently in the adult.

In summary of the differential diagnosis of acute conjunctivitis, iritis, and acute glaucoma, the objective and subjective findings may be compared in a tabulated form. Table 1.

PROGNOSIS

The prognosis of almost all serious ocular diseases, depends chiefly on their early recognition. If an acute iritis is not diagnosed, and treated early, the pupil may be blocked by adhesions between the iris and lens. This situation will cause secondary glaucoma. An acute glaucoma, if unrecognized, rapidly deteriorates in hours until enucleation is indicated. A small corneal ulcer can rapidly progress to a perforated globe in twenty-four to forty-eight hours. If there is the slightest doubt in your mind that the red eye case that confronts you in your office for diagnosis and treatment is more than a simple conjunctivitis, I would strongly advise immediate referral. In some cases this will result in early diagnosis, and prompt therapy, of a serious ocular condition.

TREATMENT OF CONJUNCTIVITIS

The number of ocular therapeutic agents available for treatment of external diseases of the eye is indeed cosmopolitan. Several pharmaceutical houses have compounded ophthalmic ointments that contain a local anesthetic, a sulfonamide, and a cycloplegic drug, in one ointment base. Obviously, a shot-gun ointment of this type is unnecessary and a dangerous therapeutic agent. I would advise you never to use them.

When possible, your choice of antibacterial agents should depend on the findings of your smear or conjunctival scrapings. When the type of organism is in doubt or unknown, I would recommend a wide spectrum antibiotic. Of these I think chloramphenicol (Chloromycetin, P D.

Table 1

	Acute Conjunctivitis	*Iritis*	*Glaucoma*
1. Pain	Slight discomfort	Moderate	Severe
2. Tenderness	None	Marked	Marked
3. Injection	Superficial	Deep ciliary	Deep ciliary
4. Pupil	Normal	Small and irregular	Large and immobile
5. Tension	Normal	Normal	High
6. Secretion	Muco-purulent	Watery	Watery
7. Vision	Good	Fair	Poor
8. Systemic complications	None	Few	Prostration, nausea and vomiting

& Co.) .16% or .25% solution, is very effective. Ointments containing both polymixin B and bacitracin, are available, aand they also are good. Of the sulfonamides, I believe sulfadiazine is the most effective because of its solubility and the small size of the crystal. It should be prescribed in a 5% ointment. Sulfacetamide as a 30% solution is effective, but it may cause burning in that concentration. It may be diluted to a 15% concentration and this will not appreciably reduce its effectiveness. Terramycin and aureomycin are effective for local use in the eye sac. I would not advise the use of penicillin locally in the eye for two reasons. First, there is a fairly high percentage of patients who will be hypersensitive to this drug. Secondly, you may sensitize the patient to the parental use of this valuable therapeutic agent. Solutions should be prescribed to adults for daytime use. Ointments are best prescribed for infants and adults for use at bedtime. It is advisable for the patient to continue the treatment for several days after the infection appears under control to prevent recurrence.

An allergic conjunctivitis responds well to Cortisone and Hydro Cortisone locally, either as a solution or as an ointment. The concentrations used are 0.5% and 2.5%.

MISCELLANEOUS DISORDERS OF THE CONJUNCTIVA AND LIDS

Pinguecula and pterygium are commonly confused by the general practitioner. A pinguecula is located on the nasal side near the corneal-scleral margin. It is a raised yellowish area which is due to hyaline degeneration of fibrous tissue in the conjunctiva. It never encroaches on the cornea, and it requires no treatment. In contrast, a pterygium is a triangular growth of hypertropied conjunctival tissue which is located nearer the nasal edge of the cornea, and it tends to grow on to and cover the cornea. It should be removed because, if it is progressive, it will cause degeneration of the underlying cornea and distort the normal curve of the cornea. Hordeolum, or stye, may be of two types. The external is present when the sebaceous glands of Zeis are involved. This inflammation will be located near the lash line, and if an abscess forms it will point in the same area. Simple incision is all that is necessary. The internal type involves the tarsal or meibomian glands, so the infection is deeper and usually farther from the lid margin. The internal type usually points through the conjunctival side of the lid. The treatment is incision and drainage. A chalazion is a tumor formation of granulation tissue which has formed by a previous internal hordeolum. The treatment is incision and curettage.

ERRORS OF REFRACTION

Eye strain from errors of refraction will produce many complaints, and it is valuable for a general practitioner to be familiar with these subjective symptoms. It will help him in his diagnostic work, as well as indicate which patients should be referred for ocular survey.

Refractive errors in infants are characterized necessarily by objective symptoms. The mother may notice inability or inaccuracy of the child in grasping for objects. The walking infant will bump into objects and steps. It is possible with cycloplegia to adequately refract and prescribe from one year of age. At a later age a more refined procedure may be used.

Hyperopia, or farsightedness, is a condition in which the light rays will focus behind the retina. The young patient can correct this defect by the act of accommodation. This constant increase in the ciliary body tone is what causes eye strain. Also, when doing close work this situation will be aggravated. These patients will complain of pain after using the eyes, blurring for close work, and headaches. In certain people nervous symptoms of a very troublesome nature may develop. In high hyperopia the distance vision may be impaired.

In myopia, or nearsightedness, the focus of light rays is in front of the retina and, obviously, there is no mechanism existing in the eye in which the rays of light may be sent back to the retina. Therefore, the myope has defective distance vision. There is usually no complaint of eyestrain.

Astigmatism is a condition in which refraction in the different meridians of the eye is not the same. Usually the astigmatic person will complain of the usual symptoms of eyestrain, both for distance and near. This is because it is impossible to obtain clear vision at any distance unless a corrective glass is worn.

Near forty years of age presbyopia first appears, and these patients will complain of dif-

ficulty in doing close work. This is due to the gradual loss of the act of accommodation. These patients will complain of blurring at close work, sleepiness while reading, and the other visual symptoms of ciliary body fatigue. This condition is corrected by addition of plus spheres to the distance correction, either as reading glasses or bifocals.

SUMMARY

The family physician frequently is the first to see a variety of eye disorders. These are often ocular emergencies, requiring immediate treatment. Prompt diagnosis and adequate therapy of injected, allergic, or injured eyes result not only in rapid symptomatic relief, but also in correction of the underlying condition and in avoidance of complications.

Accurate diagnosis is a prerequisite to the management of eye disorders. The family physician is strongly urged to care for all of the usual ocular disorders, but necessarily he should be able to make a differential diagnosis of the more serious ocular afflictions, which require specialized diagnostic or therapeutic measures.

544 Jefferson Bldg.

« « « » » »

Cystic Fibrosis of the Pancreas Eccrinosis

B. M. Kagan, M.D., Chicago

CYSTIC fibrosis of the pancreas is a disease of the exocrine glands. It involves principally the pancreas, the bronchial, salivary and sweat glands. The term 'mucoviscidosis' has been suggested because of the thick mucus secretions which are found particularly in the bronchial tree and in the pancreatic ducts and which actually block them. On the other hand the term is not particularly appropriate since the parotid and sweat glands are not mucus producing. I have therefore suggested the term 'eccrinosis' from the word eccrine or exocrine since it is a disease which affects glands which deliver their products to an epithelial surface.

It is a congenital disease and hereditary. It does not follow the Mendelian laws exactly but in general acts as though associated with a recessive gene. The usual expectancy is that one out of four members of an affected family may have the condition. However, I have followed two families in each of which four out of six children were so affected.

It is a progressive disease which is reflected in a few cases by partial pancreatic duct obstruction and later by complete obstruction. (In most cases pancreatic obstruction is already complete by the time of the initial examination.) The same progression occurs in the lungs.

Though known for only about 15 years, it is becoming increasingly recognized. About three percent of children coming to post-mortem are found to have the disease. It is estimated that one to two per thousand live births have the disease.

The prognosis today is good for the immediate future. It is poor for the long term. This depends largely upon pulmonary involvement. The earlier the diagnosis and the less pulmonary change at the onset of treatment, the better the prognosis. Since the advent of antibiotics the prognosis has been improving. Between 1940 and 1948 the average age at death was 13 months. Between 1949 and 1953 the average age at death was 45 months.

An important feature of eccrinosis is the variability in the clinical syndromes which it produces. Thus the disease may appear as intestinal obstruction in the newborn; or with

---

From the Kunstadter Laboratories for Pediatric Research and the Sarah Morris Hospital for Children of Michael Reese Hospital, Chicago. *Research on this disease has been supported, in part, by the Jessie Wertha-mer Service League.*

Presented before the Pediatric Section, Illinois State Medical Society Annual Meeting, May 19, 1954.

primarily gastrointestinal symptoms and malnutrition; or as predominantly a respiratory disease with obstruction, infection and fibrosis; or as a cardiovascular disease with pulmonary hypertension; or as a salt loss syndrome particularly during warm weather. The disease may be so variable that any one of these syndromes may be the most prominent and the others may not be present at all or not recognized unless searched for. Some children reach the age of five or six with only malnutrition as the major manifestation and with very little pulmonary involvement. Others may have severe pulmonary involvement with very little gastrointestinal symptoms. The oldest known patient with the disease is 30 years old and was found because he was the father of a child with the disease. He had never received treatment.

The disease may present itself as intestinal obstruction in the newborn because the tenacious meconium causes an ileus. This is present in about five percent of the cases. The infants vomit, have abdominal distention and may perforate either before they are born or afterward if not relieved. Flat and upright x-ray films of the abdomen should be taken. If characteristic, the x-rays show variable size of distended loops and the granular appearance of meconium. A few cases have been relieved medically by pancreatic enzymes given by enema and lavage. Most, however, require surgery and then close medical care. Under the best treatment, about 80 percent now survive this period. The most effective surgery has been by the Mikulicz resection and double ileostomy. The latter is taken down after about two or three weeks.

Many of the children have predominantly gastrointestinal symptoms. These are usually associated with malnutrition. About 70 percent of these have their onset under six months of age in contrast to the usual situation with celiac disease. Diarrhea may be present but often is not a prominent part of the picture. The stools are large, pale, foul, frothy and fatty. These children usually are malnourished in spite of an excellent appetite. Their growth in height and weight is retarded. This is easily apparent when plotted on a growth grid. The muscles are wasted and this is usually most evident in the buttocks. The abdomen tends to be large and protuberant. These infants occasionally lose blood from their nose or bowel. This is probably related to the continuous antibiotic therapy which inhibits bacterial formation of vitamin K and in addition to poor absorption of this fat soluble vitamin.

About ninety percent of the patients have respiratory signs sooner or later. These usually begin with obstruction either partial or complete causing either emphysema or atelectasis. This is followed by infection and finally fibrosis. Infants frequently have a paroxysmal cough which sounds somewhat like pertussis. They have repeated attacks of bronchopneumonia, tend to have bronchiectasis, clubbing of the fingers and later cyanosis. The respiratory disease is a frequent cause of death.

When these infants have survived to over the age of two years and if there is considerable pulmonary disease they may develop cor pulmonale with pulmonary hypertension.

During warm weather they excrete sweat with an excess salt content. As a result the blood volume tends to diminish and renal failure ensues. They may go into shock and die as a result.

Laboratory aids are essential in establishing the diagnosis of this disease. In view of the implications for the family, the prognosis and the required treatment, the diagnosis should not be made without the proof which can be obtained by these laboratory aids.

The most important of these is the examination of duodenal fluid. Of the examinations done with duodenal fluid the most important are the tryspin determination and the viscosity. About 90 percent of the patients show an increased viscosity of the duodenal fluid and almost all show absent to very low tryspin concentrations.

Examination of the stools for trypsin is useful as a screening test. Undeveloped x-ray film placed in 1 to 5 and 1 to 10 dilutions of stool will show digestion of the gelatin on the x-ray film. About 80 percent of the patients show a negative stool trypsin prior to treatment. One must watch out, however, for false positives due particularly to the gelatinase produced by such organisms as proteus and pseudomonas and also for occasional false negatives. It is best to run a stool culture especially for proteus and pseudomonas at the same time. The stool fat is increased and extracellular starch may be seen on microscopic examination in some cases.

In untreated cases, the fasting serum vitamin

A and carotene levels are low. The disease is distinguished most easily from celiac disease by the absence of trypsin. However, another interesting difference is in the absorption of vitamin A. Thus is eccrinosis, vitamin A alcohol in aqueous dispersion is absorbed fairly well but vitamin A ester in aqueous dispersion or vitamin A in oil are not absorbed well. In contrast, in celiac disease none of these forms of vitamin A are absorbed well. X-ray of the chest may reveal changes already discussed and the patchy atelectasis and emphysema may be highly suggestive of the disease. Electrocardiogram may show the right heart strain of cor pulmonale. Where feasible, testing for the sodium and chloride content of the sweat will reveal them to be very high.

The treatment of eccrinosis consists of a high calorie, high protein, moderate fat diet with frequent meals. Some children tolerate more fat than others. In general it is found best to avoid butter, cream, ice cream, mayonnaise, fried potatoes and peanut butter. Infants may do well on a casein hydrolysate or dried skimmed milk powder with carbohydrate. When these infants or children are sweating, as in warm weather, they should be given an increased salt intake. Vitamins A, D and K should be given in aqueous dispersion and vitamins A and D in about twice the normal dose.

Acute infections must be vigorously treated by parenteral or aerosol routes. The choice of antibiotic or sulfonamide should depend upon the probable and later the identified infecting organism or organisms — their in vitro sensitivity or the clinical response. All these children should be given prophylactic treatment daily with a broad spectrum antibiotic such as one of the tetracyclines in a dose of five milligrams per pound twice daily or with a sulfonamide. One of the serious and as yet unsolved problems is pulmonary superinfection with resistant organisms, particularly pseudomonas and resistant staphylococci.

Replacement therapy in the form of viokase or panteric granules in a dose of ¼ to ½ teaspoon is given with each meal. Older children may take 2 to 4 tablets with each meal. We have recently developed a semi-quantitative method for determining trypsin in the stools which we use as a guide to the dosage of replacement therapy.

In a disease which has such emotional ramifications for the child and for the siblings as well as the parents a considered psychologic approach is obviously of importance.

In general, it is wise for these children to avoid unnecessary exposure to infection. They should be given routine innoculations. Good nursing care and close medical supervision are important.

In occasional cases antihistaminics, bile salts and expectorants appear to be helpful.

In closing it is worth reflecting that the day liver was discovered, the future of patients with pernicious anemia changed; the day insulin was discovered changed the future of diabetics. It is worthwhile to prolong the lives of these children for obvious reasons and also because one day could mean such a difference for them. I mentioned the father of one patient who is 30 years old but has had the disease and never had treatment. Dr. Anderson who originally described this condition now has 23 patients under observation who are over ten years of age. With further research the future for these children may be brighter.

‹‹‹ ›››

Aging

Individual aging begins with cell division and has three stages: (1) growth (development, (2) maturity (stability), and (3) senescence (decline). There are seven kinds of age: chronologic, anatomic, physiologic, psychologic, pathologic, statistical, and hereditary. *C. Ward Crampton, M.D., Medical Services in Aging and De-aging. New York J. Med., Oct. 15, 1954.*

Elective INDUCTION OF LABOR

A Symposium

Robert N. Grier, M.D., Willard C. Scrivner, M.D., Edwin J. DeCosta, M.D., James E. Fitzgerald, M.D.

Robert N. Grier, M.D., Evanston

Any doctor who attempts to start labor by any artificial means is subject to criticism if the results are not satisfactory. There are many instances when a medical procedure will not be satisfactory. Often the attempt fails and the patient has to be sent home; because labor did not follow. This is a "dramatic" calamity to the patient involved.

It is my contention that this situation need not happen.

The proper selection of patients, who have conditions which indicate that labor is imminent, are the only ones we should arbitrarily attempt to induce. This is aside from any therapeutic indication for induction such as toxemia, diabetes, etc. when the patient might be subjected to a more prolonged or "tougher" labor justifiably as a lesser risk than doing a cesarian section to terminate pregnancy.

The spontaneous rupture of membranes, for which only nature or the natural courses of events can be blamed has shown us the pitfalls that this occurrence can produce. These are, a prolonged latent period and a prolonged labor when the cervix was not "ripe", a possible prolapse of the cord, when it is long, and the head was floating; infection as a result of the amniotic sac being subject to ascending infection over too long a period; to mention only a few.

But if the obstetrician who is watchful of conditions and events, observes the following conditions I think the procedure is warranted and will be satisfactory.

Presented before the Section on Obstetrics and Gynecology, 113th Annual Meeting, Illinois State Medical Society, Chicago, May 19, 1953.

The Proper Conditions

1. The patient should be within one week from her expected date of confinement.
2. The baby should seem to be of appropriate size.
3. As predetermined by mensuration and past history of deliveries no disproportion should be suspected.
4. The head should be "dipping well" into the pelvis or, in other words pressing well against the cervix, not necessarily engaged but preferably so, certainly not floating. A breech presentation is a contraindication.
5. The cervix should be effacing, that is thinning and softening.
6. There should be some actual dilatation, at least to 1.0 cm. or more.
7. There should be no signs of a faulty presentation, or attitude from abdominal palpation. If questionable an x-ray picture is indicated.

By the same criterian I would like to mention the conditions which would not be contributary to a successful attempt of elective induction of labor.

1. The E.D.C. should not be considered as criteria for induction per se no matter how long this date is passed.
2. One should be able to assess that a baby is large enough to survive; this does not mean that one should be concerned that it is getting too large because it is "overdue".
3. If the cervix is thick, uneffaced and tightly closed it means that labor is not imminent and even though the head is engaged and the woman is "overdue" it is foolish to attempt artificial induction.

4. A breech presentation is definitely not one for the rupture of the membranes. These membranes are to be conserved at all cost, in this presentation. They are a definite aid in completing dilatation and in preventing prolapse of the cord, which is more likely in this presentation, should they rupture.
5. Whereas, when the baby is known to be dead, it may seem humane to end the pregnancy. This should not be attempted unless the ideal conditions mentioned above are present.

Though it can be said that no labor should be started by any artificial means it is my contention that labor under many circumstances can be made easier and safe by so doing. To mention a few:

1. The patient who gives a history of frightening precipitate labors and who may live some distance from the hospital.
2. The patient who states that she was not aware of her pains in previous labors, and thus deliveries precipitately.
3. For convenience of making arrangements for the care of other children in her household, especially if the husband will not be home at the possible time of labor.
4. It is possible for these patients to go to the hospital at a convenient hour with no rush or fear, during agonizing pains.
5. Preliminary preparation, such as perineal care and enemas can be given without the frantic stress of precipitate labor.
6. A time for all this can be arranged when the maternity personnel can best deal with these preparations and subsequent delivery.
7. To say nothing of the possibility of the obstetrician being able to arrange the best suitable time for himself to be present throughout labor. This presence seems to me the intangible something that gives comfort to any patient.

Willard C. Scrivner, M.D., East St. Louis

I DON'T think any of us have the task this afternoon of trying to tell how to induce labor. In 1929, as an assistant resident, I was more or less impressed by the number of women entering into labor which had started after the spontaneous rupture of the membranes. A careful study as far as I was concerned convinced me that it was a worthwhile procedure, and it stands today as an acceptable obstetrical procedure just as pneumonectomy in general surgery. You have seen some of the advantages. Not every delivery is a case for the induction, elective induction, that is, of labor. I would accept your ill feeling on such a remark.

I come from East St. Louis where we have two hospitals. They are divided; one is Catholic, and the other is a Protestant Hospital, and there is a small obstetrical service in one. People are divided as to where they want to go to have their babies.

The following rules are the ones which I have set down for myself. I never consider induction of labor in the following cases: breeches, floating presenting parts, malpositions, or in women with a history of menstruation from twenty-eight to forty-two days. It must be an accurate twenty-eight day cycle or less. Women where the presenting part, if a primpara, is fixed in the inlet, women in whom there is any vaginal infection such as monilia or trichomonas. We do a vaginal examination each week during the last month of the pregnancy in my office, and probably this will sound unheard of, but I practically always use chloroform as the anesthetic which is given by the nurses.

Now for the reasons we induce labor. First, a lot of people have heard about it and like it. If the husband has the car and is working during the day, there is the problem of transportation. Then there is the problem of making arrangements for their family. Thirdly, they want to make sure there will be a bed at the particular hospital where they want to go. Now these are the reasons the patients give. Now as far as I am concerned, if rupture of the membranes is done at six-thirty in the morning or seven o'clock, one can do early morning surgery without being harassed by a precipitate delivery. I don't have hurry-up calls, and can deliver the patients more leisurely. Then, too, the labors definitely are shorter when the cases are selected.

Now, maybe some of you are better trained, but I work better during the day than I do at

Assistant Professor of Obstetrics and Gynecology, Washington University School of Medicine, St. Louis, Mo.

night time. We have better hospital personnel taking care of the packing, the transfusions, the blood drawing. Of course, there is a special technician who can always be reached by telephone, but you may have less desirable personnel on in the evening, or the afternoon shift. When you don't have precipitate deliveries, you have less emotional upset for the patient. Formerly there were always some patients who died as as result of aspiration of gastric contents. Our patients get nothing after midnight, so you know that the stomach is going to be empty and you don't have to worry about that.

Let there not be any misunderstanding. In elective induction of labor you are on the defensive. To confirm what the preceding speaker said, I ask my patients, if the case is suitable, "Will you be interested in a baby by appointment?" If she says, "Well, I'd like to talk to my husband about it," if she hesitates, as far as I'm concerned the deal is off. She has to accept right away. I am going to tell you a little story about that in a minute. You are on the defensive in your own conscience, and when the obstetrical department chairman or the medical staff or the hospital administrator are keeping those red lists, you are not going to make any mistakes in selections of your patients. These are the cases where in our experience you are going to be able to successfully terminate this labor in a relatively short period of time without any morbidity or mortality provoked by the interference. If you can't answer those things in your own conscience, then you are not doing the procedure right. Personally I use nothing except rupture of the membranes. If the patient doesn't get contractions in forty-five minutes we will give one-half minimum of Pituitrin, and if that fails we might try it one or two more times. Now in certain instances we employ the so-called drip which is a new lethal weapon which is very helpful when used properly, in the induction of labor. Personally speaking, I had my wife have it twice, that is induction which we use in our backward area. In one of our institutions we had about twelve or fifteen hundred deliveries where the nurses examined the patients, the doctors examined them, and the specialists examined them rectally or vaginally, and it may surprise you that we had no more morbidity than in the places where they regularly avoid vaginal examinations for the dirty gutters of the rear. As far as induction of labor is concerned, there are two sides of it. I remember one lady during the war years whose daughter was having her baby, and when the delivery was over, the grandmother came to see the baby. When she saw her granddaughter, she said, "I thought sure enough it'd be a boy." That is one side of it. Then there is another side of it. I remember the lady who said, "Doctor, bring me my baby by appointment. Could you tell me whether it will come before noon or not, because my husband wants to know whether to lay off work or not."

Edwin J. DeCosta, M.D., F.A.C.S., Chicago

I AM not quite sure that I understand the meaning of the title of this symposium—"elective induction of labor." Any induction of labor is elective. Otherwise it could not be an induction. Perhaps what we really mean is the induction of labor in the absence of medical indications. If there are no medical indications, why induce labor? One might be heretical enough to mention the prime considerations: convenience of the doctor and convenience of the patient or her family. To be less realistic is to delude ourselves. A better term would be "selective" induction of labor.

Postmaturity, fear of intrauterine fetal death, too large a baby, etc., are certainly medical indications. But when one hears that Doctor A delivers his babies on Wednesday and Saturday, no cloak of words can cover the bare fact that someone's convenience is the prime consideration. Now, I do not necessarily say that this is wrong —unless either the patient or her child suffers. Whether the latter occurs depends on the method of induction and the attention paid to details.

Labor may be induced by medical means, by surgical manipulations or a combination of the two. Medical induction falls into two main categories: (1) bowel stimulation, either by the use of purges or of enemas; and (2) uterine stimulation by the use of drugs to increase uterine irritability or to stimulate uterine contractions. A word about each: Experience has established the fact that bowel stimulation reflexly leads to uterine contractions. However this phenomenon generally occurs only late in pregnancy,

and at a time when the uterus is ripe and ready to extrude the products of conception. Witness how frequently caster oil or enemas fail to induce labor. One might question whether purging is desirable. During labor the loss of fluids may be great and during labor the intake of fluids is minimal unless administered parenterally. Is it therefore good medicine to dehydrate a patient at the onset of labor? I don't think so; hence I rarely use caster oil. However, the enema is different. It is good practice to clean out the bowel and frequently labor does begin if the enema is given—high, hot, and a hell of a lot.

Turning to drugs used to increase uterine irritability, we have time honored quinine. Quinine however is apparently ineffectual. Pregnant patients treated with quinine for malaria do not have premature deliveries. In addition, quinine may be dangerous to both mother and baby. Serious allergic reactions have been reported as well as 8th nerve injury and even sudden death of the fetus. I do not use quinine. Nor do I know of any effective drug or hormone useful for increasing uterine irritability.

Let us consider the oxytocic drugs which do stimulate uterine contractions. The ergot preparations as of the present moment are too dangerous for aught but condemnation. Posterior pituitary extract however, where judiciously used, can be exceedingly valuable. I don't believe it makes much difference whether the preparation is ordinary obstetrical pituitrin or pitocin. The oxytocic actions are similar and vasopressor effects have been observed with both preparations[1].

Pituitary extract may be employed in many ways. Intranasal pituitrin is not too reliable, often ineffectual, but still used[2]. Subcutaneous and intramuscular pituitrin in ½ to 2 minim doses have many advocates. Pituitrin may be used intravenuously in minute doses by continuous infusion. The latter route seems to me to be the only logical method of administration because it is the only way in which the action can be completely controlled and in which effective administration can be maintained over a period of time. In addition, it is significant to note Reynolds' observations that intramuscular injection is commonly followed by reversal of dominance of uterine activity between the fundus and mid-uterus, whereas continuous intravenous infusion will commonly augment the dominance of fundal activity[3]. Since normal dilatation of the cervix involves the establishment of a gradient of fundal dominance over the rest of the uterus, it follows that intravenous pituitrin should lead to progress in labor whereas the results from other methods of administration may be less effective.

Intravenous pituitrin may be administered in a great variety of dilutions. I have progressively reduced the amount of posterior pituitary extract and at present use only 5 minims to a liter of 5% glucose — a dilution of 3.3×10^{-4} milliliters of pituitrin per milliliter of solution. Generally only 30 to 60 drops a minute are necessary to induce and maintain labor in the properly selected patient. Some patients, however, will not respond. In this case you would be wise to desist — the patient is not ready for labor. Incidentally, the I.V. drip hydrates the patient and may be safely carried through and beyond the 3rd stage.

Assuming that their is purpose for the induction, and eliminating allergies, the only contraindications are mal presentation, cephalo-pelvic disproportion, hypertension, and grand multiparity. It is preferable not to administer pituitrin to the patient who has had over three pregnancies. Ruptured uteri have occurred in multiparous women without cephalo-pelvic disproportion or evidence of uterine abnormality.

Surgical induction includes a variety of procedures. The oldest, dating back to Soranus, is simple rupture of the membrances, amniotomy. It is also the most effective, if the patient is properly selected and the liquor drained off. Fear of intrauterine infection, prolapsed cord, and prolonged labor has given rise to a less effective method, namely, stripping the membranes (and quietly dilating the os a bit, though never mentioning it). This method is not without risk of infection but with proper selection is usually satisfactory[2]. Extra-ovular bags have been used for years. They too can lead to infection and are frequently ineffectual in inducing labor. Bags are rarely employed at present.

The proper selection of the patient has frequently been referred to. Here lies the crux of success or failure. Proper selection implies the existence of certain conditions prior to induction and on this most authors agree: (1) The

head should be engaged. (2) The patient should be near, at, or beyond term. (3) The cervix should be soft, effaced, and dilated one or more centimeters.

These requirements are not too often met. How often do you see multiparous patients with engaged heads? Yet this condition is essential if one is to eliminate the danger of prolapsed cord. How then can men induce the majority of their patients on specified dates? The answer is obvious: they do so without meeting the conditions, they take a calculated risk, and sometimes they find themselves in trouble. Today we get out of trouble through the use of antibiotics and cesarean section. But how much better to have avoided the trouble! What if we miscalculate the size of the baby, or fail to recognize twins? Again we can pull out ture nursery if one is available. But that too of trouble by sending the baby to the prema- does not constitute good therapy.

In addition to careful evaluation of the size of the baby, it is necessary to emphasize the importance of proper examination of the pelvis and the cervix before induction is undertaken. This can best be done by a careful clean vaginal examination—rectal examination is moderately informative, but your final decision must be based on vaginal findings. You will determine whether the cervix is "ripe" and whether the head is engaged or can be impressed. It is best not to rupture membranes in a patient with a breech presentation unless the breech is deeply engaged and the cervix is already dilated.

If you strictly observe the accepted conditions, you will be gratified with the response to induction and will not endanger either fetus or mother. Whether you continue to call nonmedical induction "elective induction" is of no great moment. Convenience can be a true indication—in those instances where the patient is past term, apprehensive or living at some distance from the hospital. But you must pick your patients carefully and *attend them throughout the entire induction.*

To sum up, my preference is for the following routine, which has been eminently satisfactory to date: a 3 H enema; careful vaginal examination, and rupture of the membranes if the afore-mentioned conditions are met; followed by intravenous infusion of very dilute posterior pituitary extract. Again, as a final word, I must reemphasize that the obstetrician must be willing to be in continuous attendance during the intravenous administration.

104 S. Michigan Ave.

BIBLIOGRAPHY

1. Jackson, R. L. and Decker, D. G. Some observations on the pressor effect of an oxytocic agent used intravenously. Proc. Staff Meeting Mayo Clinic **28**:20, 1953.
2. Colvin, E. D., Bartholomew, R. A., and Grimes, W. H. The problem of delivery of the nonresident patient. Am J. Obst. & Gynec., **54**:755, 1947.
3. Reynolds, S. R. M. Physiological bases of gynecology and obstetrics. C. C. Thomas, Springfield, 1952. p. 36.

James E. Fitzgerald, M.D., Chicago

ELECTIVE induction of labor as I understand it is induction without fetal or maternal indication therefor. It is a procedure for the convenience of the physician or mother or both. On this basis it may serve a useful purpose.

At Cook County Hospital where we deliver some 900 patients monthly we manage without elective induction. Many factors explain this situation. We are primarily a teaching institution and we are interested in demonstrating to our internes and residents the excellent obstetric results that can be attained with a minimum of interference with normal processes. We feel that our residents in particular should have wide experience in the patients' ability to deliver after spontaneous onset of labor with excellent results for both mother and child. We know that these trainees will increase their indications for interference once they have left the training ground but wish them to start with a good background of conservatism. Their training in various methods of induction is not neglected, but it is learned on patients with a maternal or fetal indication for the induction.

Other institutional factors limit our need for elective induction. With a very active service extremely short of nursing personnel, we find it unwise to use any unnecessary procedures which adds to the nursing load. By the same token a relatively limited medical personnel is less able to watch for the possible complications that may follow inducation of labor. Thus prolapse of the cord is less likely to be discovered promptly. Likewise, the theoretical possibility

Professor of Obstetrics and Gynecology, Northwestern University Medical School, Chicago, Ill.

of fetal danger in the presence of quinine would be discovered less promptly. Changes in blood pressure and the rare drastic uterine contractions due to pituitary products are factors in our failure to use the elective induction of labor.

All in all then, we find that in an institution of this kind there is no need for, and no advantage in the procedure. On the other hand, we have no quarrel with those whose facilities allow them to use the method with safety. Our own experience in private practice has been less gratifying than that of Dr. Greer. Success has been less than universal when simple methods are used. In properly selected cases rupture of the membranes almost always starts labor, but the occasional case that refuses to conform can decrease the coronary flow of the physician in charge.

In conclusion then, I think that the use of elective induction depends primarily on the type of patient and hospital facilities. Where the hospital is overcrowded, when there is a shortage of medical and nursing personnel, elective induction has little place. On the other hand, with better hospital facilities, more help, and when proper obstetric conditions are present, elective induction should be a feasible procedure.

104 S. Michigan Avenue

DISCUSSION

Dr. Hubert L. Allen, Alton, Chairman: The Symposium is open for questions.

Dr. Redmond: I would like to ask Dr. Scrivner whether he makes a routine vaginal examination during labor.

Dr. Scrivner: I would say that 90 per cent of the examinations that take place during labor are done vaginally either by my associate, myself, or our obstetrical nurse. Of course, if we know we are going to induce a patient on whom we are going to do a section, or if she comes in with ruptured membranes and we think may be an operative procedure will be necessary, we occasionally do just a rectal examination provided we get the information. May I say here, and the records will prove it, that we had a hospital survey of one year's diversified cases in which we made rectal and vaginal examinations, and the temperatures were taken every four hours, at eight, twelve, four and eight, and we had less than the average percentage of morbidity for the state by far.

Dr. Elliott: Three years ago a big fat girl came into my office. During the course of four days she had a blood pressure of 210 or over systolic, and a test tube determination showed 4+ albumin. She was about one week overdue. I asked for consultation and was advised to put the patient to bed and give magnesium sulfate intravenously. In the course of three days her blood pressure dropped to 140. The consultant again saw the patient and advised that an enema may be given, and after two hours give 10 grains of quinine and repeat in an hour if necessary. We did that; labor started and she delivered two babies, both living. Was that the proper thing to do?

Dr. DeCosta: The answer is "yes". You had a proper medical indication for induction of labor. The patient had suffered a severe pre-eclampsia, and even after treatment still had a mild pre-eclampsia. The enema alone may have induced labor. We see that frequently.

Dr. Elliott: Are there any ill-effects from the quinine?

Dr. DeCosta: Quinine is not considered innocuous. Babies have been observed to die suddenly or to be born deaf.

Dr. Hauch: I would like some information regarding maternal mortality, and maternal and fetal fatalities. I wonder if Dr. Grier would comment on any changes in elective inductions in that regard over those that went into labor spontaneously.

Dr. Grier: In the series reported today and in a larger series previously reported, we did not find any higher incidence of fetal damage or morbidity. All our babies lived; two weighed 2750 grams and the average was about 3000 to 3400 grams.

Dr. Steinbring: I wonder whether Dr. DeCosta's remarks would apply to an approaching vacation.

Dr. Grier: I will answer that question. I do not let vacation interfere; I get some one else to deliver the patient.

Question: Dr. Scrivner said that menstrual irregularity was a contraindication to elective induction of labor. I would like to ask Dr. Grier if he would consider this a contraindication if other conditions were present.

Dr. Grier: If there is a history of irregular menstruation, the woman should probably be

allowed to go a little longer. However, one should be able to estimate whether the baby is of normal size. In our series if the approximate weight was less than 2700 grams the patient was not delivered.

Question: Dr. Grier, did you find any more postpartum bleeding than in spontaneous deliveries?

Dr. Grier: We did not.

Dr. Scrivner: It is my opinion that women having short labor have less fatigue if they have been on a salt-free diet during the last month of pregnancy.

Dr. Howard Penning, Springfield: Has there been any consideration given to the use of intravenous pitressin before rupture of the membranes?

Dr. Fitzgerald: That depends upon whether you are talking about straight elective induction. At the Cook County Hospital, if induction is to be started we give intravenous pitressin before rupture of the membranes. We occasionally rupture the membranes, but that is in an induction which is done for medical reasons. If it is the straight routine elective induction that Dr. Grier is talking about, I do not know. I still think that for induction I would start the intrevenous pitressin before the membranes ruptured.

Dr. Young: I would like to ask Dr. Grier how many failures he had in his selected cases which met all the requirements.

Dr. Grier: I do not know that you could call any of them failures, since all the patients delivered and in none were the labors longer than twelve to eighteen hours. This should not happen if the selection of the patients is right. If you do not have ideal conditions it is best to wait and probably in eighteen to thirty-six hours the cervix will efface and the patient will go into labor. I do not induce that kind of patient. I induce patients where labor is imminent. I think the term should be changed to "selective" induction rather than elective.

Dr. Ray E. Bucher, Danville: We have had a little of both, or all three methods going on in Danville — with the intravenous inductions, and we have had a little trouble at one time with the induction with ergotrate which was mentioned. We rule that out more or less in our department because we have had two or three instances where small doses of ergotrate produced the first contractions which were very violent, and in one or two instances we have had intrauterine fetal death subsequent it its use. In one instance we had a ruptured uterus. In our hospitals we use no ergotrate prenatally, and have not used it for quite a while. I am quite interested in this problem of getting labor induced by just simple rupture of the membranes. I have had the experience of having two patients during the past two years whose membranes ruptured with continuous drainage necessitating the wearing of pads for two and a half to three months. One of them delivered a dead fetus, and the other spontaneously delivered a normal infant after she had had a hemorrhage. The hemorrhage was caused by premature separation of the placenta, but she had had two other children, and delivered very rapidly and got a good baby out of it. I personally would be a little fearful about inducing labor by that means, although others in town have done it and are getting along very well. I think I am becoming interested.

‹‹‹ ›››

Make Reservations Now For

Your Annual Meeting — May 17, 18, 19, 20

The Practice Of Medicine In 1787

Lester S. King, M.D., Chicago

An old volume, evidently a dispensary record for part of the year 1787, recently came to my attention. It seems of sufficient general interest to warrant reporting in some detail. The book, of ledger format, contains some 260 pages of script, as illustrated in Figure 1, and covers the dates from June 1, 1787 to January 25, 1788. Although no extrinsic identifying marks are present, internal evidence indicates a Scottish locale. The entries apparently describe both home-visits by the doctor, and patient-visits to the dispensary. We find recorded therein the day-by-day conduct of Scottish medicine in the latter part of the 18th century. There are no discoveries recorded, no feats of special diagnostic skill. But by studying the notations we can get some insight into the mental processes of the physician and the aspects of medicine which he deemed important.

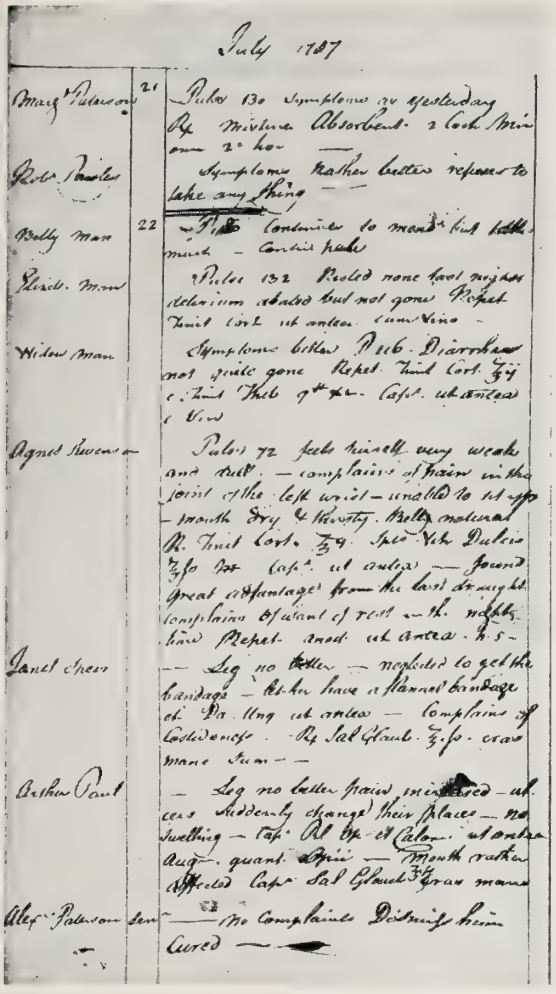
Whenever new patients are seen for the first time the record gives a brief note of age, history and physical findings, and the treatment. Successive entries may indicate the progress or additional therapy. In many instances the case is followed to the final outcome, but all too often only a few entries appear, and then the patient drops from sight. On the other hand the death of patients is frequently recorded, occasionally with autopsy findings.

Most of the entries concern the follow-up on old patients, and we see such items as "Better, Cont. Med." "Rep^{r} Solutio" or "Rep^{r} Pil. opii". or "Rep^{r} Mistur. Pector. ut antea" or very very commonly, "Da Vin. Rub. oz. viii". Frequently there are very short progress notes to this general effect: that the pain continues but not so severe; or the ulcer looks better but is still painful at night time; or the swelling is quite gone, and the like. It is very frustrating for the reader, to find scattered progress notes with no original history; or an interesting original history but only slight and incomplete follow ups. There are numerous cases, however, where there is sufficient information to yield a fairly well rounded picture.

One fascinating patient is Elizabeth Speir, aged 48. When first seen, July 7, 1787, she had a "pulse 90. Swelling of her belly which began about a year ago, and gradually increased since; liver seems enlarged with evident fluctuation of water in the cavity of the abdomen — Sense of smothering and pain when she lies with her head low which distresses her very much in the night time and other symptoms of hydrothorax. The peritoneum and abdominal muscles seem ruptured, as the peristaltic motion of the intestines is plainly perceived through the teguments. Menses irregular for a year past. Appetite bad. Belly natural." No diagnosis was made, but the treatment consisted of powders of dried Scilla root and cream of tartar, taken every three hours.

Over the next three months she gradually became weaker, in spite of occasional transient improvements from a diuresis. By September 7 the "Swelling of her belly and limbs gone and has little other complaint than weakness," but a week later the "Swelling has returned almost as much as ever." Increased amounts of diuretic were prescribed. Only a few and non-informative entries appear through October. On November 15 we find this final note: "Died yesterday forenoon and her body was opened this morning — few or no muscles were found on dissection the omentum and colon were in a diseased state and very much shrunk up — the liver and spleen were greatly enlarged and in a schirrous (*sic*) state and a large quantity of water was taken out of the abdomen." And that is all. There is no mention of the thoracic organs. Obviously the differential diagnosis of the dropsy had not come into its own, but presumably this was a cirrhosis of the liver.

From the Illinois Masonic Hospital, Chicago.



July 1807

Mary Paterson 21 — Pulse 130 Symptoms as yesterday Rx Mixtura Absorbent. 2 Cochl. Min. ampl. 2° hor. —

Peter Fowler — Symptoms rather better refuses to take anything —

Wally Man 22 — Pulse continues to mend but takes little drink — Contin. pulv.

Electr. Man — Pulse 132 Rested none last night Delirium abated but not gone Repet. Haust. Cort. ut antea Cum Vino —

Widow Man — Symptoms better Pulse Diarrhoea not quite gone Repet. Haust. Cort. ℥ij c. Haust. Theb. gtt xx. Capsl. ut antea c. Vino

Agnes Stevenson — Pulse 72 feels himself very weak and dull — complains of pain in the joint of the left wrist — unable to sit up — mouth dry & thirsty. Belly natural Rx Haust. Cort. ℥ij Spt. Vin. Dulcis ℥ss Tr. Capsi. ut antea — Found great advantage from the last draught complains of want of rest — the nobility. haust Repet. haust ut antea h. s. —

Janet Shiels — Leg no better — neglected to get the bandage — Rather have a flannel bandage ol. Da. Ung ut antea — Complains of tediousness — Rx Sal Glaub. ℥ij. cras mane sum —

Arthur Paul — Leg no better pain increased — ulcers suddenly changed their places — no swelling — Tab. Rx Hydr. c. Calom. ut antea Aug. quant. Opii — Mouth rather affected Capt. Sal Glaub. ℥ij cras mane

Alex. Paterson Jun. — No Complaints Declined being Cured —

On Dec. 4 Peter McFarlane, aged 19, was seen with the following story. "Since June last has been affected w^t headache and vomiting of water and a complaint of his stomach — about a fortnight greatly increased at present violent headache — great delirium — Eyes squint. Pulse intermitting." As medication the physician prescribed opium and calomel. Nevertheless on Dec. 10, he died. "His cranium was opened. The blood vessels of brain was very much distended and a quantity of water found in the ventricles. No other praeternatural appearance." And whether he had a subtentorial tumor we shall never know. We can only surmise.

One of the most interesting cases is William Glen, age 44, who, about 8 months previously "began to find some difficulty of swallowing, which gradually increased and his victuals were at times brought up again into his mouth by an inverted perystaltic motion of the oesophagus with a sort of gurgling noise peculiar to this disease. Dr. Farquharson prescribed some powders of opium and calomel from the use of which he found considerable benefit; but the complaint has again returned and is nearly as bad as ever. He in general swallows liquids with tolerable ease but everything solid is liable to be stopped in its passage to the stomach. The obstruction seems to be further down the oesophagus than generally happens in this disease but its exact seat will be best ascertained by a long elastic whalebone probe — for most of the cases given of this disease the constriction was opposite to the 3rd or 4 vertebra of the neck. This case appears to be the *Dysphagia Oesophagia* of Nosologists; ..... He has likewise some pain in one of his haunches which appears to be rheumatic."

As treatment, opium internally, and mercury ointment externally, were prescribed. The next several days record other visits, but only with notations prescribing spirits of camphor to rub "his haunch" with, or Red Wine, or other medicine, and then he disappears from sight with no follow up.

Numerous patients exhibited neurological disease. Marion Dunbar was a veteran patient whose visits are recorded throughout the book. The present volume does not contain any details of her medical history, and most entries simply prescribe one or another medication. But one notation mentions that she "had 15 fits this morning before 11 o'clock, was roused by cold water. Complains still very much of a wife (*sic*) at the back of the bed who attempts to choak her." Some fits, noted at other visits, last as much as an hour.

Another patient, a woman of 30, "For 15 years past has been out of her senses and at times subject to convulsive fits is very ill natured and will do nothing but what she pleases. Sleeps none except that which she gets from Laudanum. Has been using it this some time and she bears a great quantity."

In contrast to this probable epileptic is the case of a 9½ year old girl who "Has been for some time past has been (*sic*) troubled w^t worms attended w^t purging of blood. She likewise complains of a weakness of her left side and a paralytic affection of her tongue," or a 15 year old boy for five years past has been subject to a

sever (*sic*) pain of his head accompanied with vertigo — loss of sight and stupor — these symptoms often continue for several days during which he is almost constantly in a deep sleep — when awake he appears to be an idiot and loses his strength entirely — P. 90 and regular — appetite natural." Unfortunately there are no further data, no follow-ups, no physical description. In terms of modern nosology we can only speculate on the underlying condition. The therapy offered in 1787 included powdered ipecac and tartar emetic, precipitated chalk and gum arabic, powdered jalap and the application of vesicants. In the same vein but again without follow-up we read of a 30 year old woman who "for some time past had affected w^t a Paralysis of her arms and legs attended w^t Sickness and numbness over her body Pulse 100 Belly bound." Here too we find prescriptions for ipecac and tartar emetic "pro vomitu", and powdered jallap (*sic*) and calomel for the next morning. It is not entirely clear whether the treatment was directed against the paralysis, numbness and sickness, or against the bound state of the belly.

There are several cases which suggest renal impairment of one or another type. One 6 year old girl "For 4 months past has been subject to dropsy her belly at present is swelled to a remarkable degree — great thirst, belly bound makes little or no urine and for 3 weeks past has been obliged to rest upon her knees and elbows —". For this condition scilla was prescribed. In a very comparable case, a girl of 14 "For 4 months past has been affected w^t ascites, complains of great pain in her bowels and difficulty of breathing makes no water. Pulse quick and feeble." Here, in addition to scilla, the doctor prescribed jalap and cream of tartar, and also 8 ounces of AquaVitae, "a little to be mixed w^t Juniper tea and given for common drink."

There are some vivid examples of arthritis. A 13 year old boy "For several days past has been afflicted w^t violent Rheumatic pains in his legs and arms which have almost deprived him of the use of them they were brought on by standing in the river some hours and neglecting to shift afterwards. Skin hot P. 100 and full belly bound." Medication here consisted of elixir of guaiac, wine of antimony and tincture of opium. Further prescriptions included calomel, scilla and jalap, and powdered rhubarb. Eleven days after the first entry, we find the laconic progress note "Better". Improvement apparently continues, and by the lapse of 3 weeks we find Rx. Oppodeldoch oz. ii Sig. To rub his knee w^t." This is repeated and then he drops from sight. Apparently the polyarthritis resolved, leaving only one knee still painful.

Two cases of gastro-intestinal bleeding, presumably peptic ulcer, offer material for speculation. The first was a 44 year old woman who was first seen on Oct. 30, with rather banal and non-committal symptoms. "Since Friday last has been affected w^t great pain in her breast and breathlessness likewise pain of her head great thirst belly bound." Since the "breast" can apparently mean any part of the trunk between the diaphragm and the neck, this entry is not very informative. On two subsequent visits she received new medications, and there is the single comment "Better". But on November 13 there is a marked change in her condition: "Complains of sickness after her meals particularly her breakfast the more so if her food is liquid. On Friday last w^t a dose of salts she passed a large quantity of a liquid as black as ink which she did last year twice the first time black and second of the colour and consistence of blood." In spite of this the doctor prescribed continuation of the cathartic salts. It is highly significant that this is the last entry for this patient, even though the book continues for 2½ months. We might guess, perhaps, that she consulted another physician.

The second case is a 45 year old woman who "about a twelve month ago was attacked w^t a vomiting of blood. Since which time she has had three returns of it. Three days ago it attacked her again the stools are of a black colour — has no cough nor pain of her breast but complains of a pain in her left side which has continued more or less this year and half. Pulse 96 and rather feeble — Tongue a little furred belly natural." Four days later we find that "The vomiting of blood has disappeared. She complains of the menstrual flux being small quantity — is much troubled w^t erratic pains and flatulence. Pulse 80 and feeble. Tongue foul belly much constipated." To correct this she received castor oil and tincture of senna. Apparently no harm ensued. The book comes to an end after recording

one more visit which is not contributory, so that again we do not know the outcome.

Infectious diseases formed a major part of the doctor's practice. Most often the descriptions are vague and unsatisfactory. Of children, for example, we repeatedly find such entries as ,"A typhus of 4 days standing", or "Nervous fever of 6 days standing w^{t} pain of his belly and looseness." Somtimes the descriptions are a little more specific. Thus, a four year old girl was "affected with swelling and inflammation of throat which came on about 3 days ago — fauces swelled and white — has been blooded with Leeches yesterday and took a purge last night which operated well. Breathing at present easy but swallows w^{t} difficulty." But the next day her "febrile symptoms" had disappeared, although the throat was still inflamed. Within two days symptoms (without qualification) were "mostly gone", so she could not have been very seriously ill. It is of interest that bleeding, whether by leeches or venesection, was very infrequently prescribed.

Tuberculosis was one of the few diseases to receive identification, although in rather tentative fashion. A young 21 year old widow complained of "general soreness over her body, pain in her bones difficulty of breathing with great debility cold sweats in time of sleep which greatly weaken her, severe cough chiefly in the night time, spitting rather diminished these two days last — Eyes have a consumptive appearance. No menses since the beginning of May last Pulse 86 Belly rather bound tongue moist. Complaints began about 6 months ago but greatly increased about ten days since." Or another patient, "aged 16 — about 7 months ago was seized with a sever (*sic*) cough — pain of the breast — dyspnea — night sweats occasional diarrhea — copious expectoration and all the symptoms of phthisis — pulse 120 — for several days past he has complained much of a pain in the left side with inability to ly on the opposite."

In addition to phthisis or consumption, there are many references to "scrophulous swellings". One of the most vivid is a 30 year old man who "For two years past has laboured under a scrophulous affection of the wrist and back of the left hand which is now degenerated into a number of fungous ulcers and spongyness of the carpal and metacarpal bones. He has likewise been afflicted w^{t} a severe pain of the small of his back probably owing to an affection of the mesenteric glands. This last complaint is of 3 or 4 years standing. Pulse small and feeble — Face pale — Body Emaciated." Or the 19 year old girl who "For 13 years past has been troubled w^{t} Scrophulous runnings upon her left thigh and leg which is greatly drawn up — at present there is a large tumor upon her thigh which appears to be in a state of suppuration pulse 100".

Gonorrhea was well recognized. Thus Ann Wallace, "Aged 32. About 6 months ago was affected w^{t} Gonorrhea attended w^{t} pain and heat in making her water for which she got several medicines since when the heat and pain in making water have gone but the running continue." For injection a very remarkable mixture was prescribed: Calomel, sugar of lead, white vitriol, "crabs eyes", (oculi cancrorum precipitati), opium and gum arabic. We do not learn, however, whether this was successful. Another patient was a 14 year old girl about whom it says only "For two months past has been affected w^{t} a virulent gonorrhea", received a much more prosaic remedy, namely, oil of sweet almonds and mucilage gum arabic for injection, and the next day opium, and extract of lead in gum arabic. Two weeks later she is noted to be "better", and then is followed no more.

Syphilis is not mentioned by name but is referred to as a disease "of venereal nature." A 33 year old man "Has complained for 3 years past of a sore throat which was better times but is again much worse and the uvula is a good deal decayed. Complains much of costiveness and restlessness in the night time. It appears to be of a venereal kind." He received mercurial pills, and two weeks later "Throat looks better but thinks the pills begins to affect his mouth." A few days later "Ulcer better but complains much of faintishness." Further information we do not possess.

There is remarkably little in the way of surgical practice, and the few cases of a surgical nature are briefly recorded, without follow-up visits. Under the date of June 5 we find this for one patient's entry, "On the 3^{d} instant the operation of Lithotomy was performed on him and a large stone, weighing 3 ounces and half was extracted." There is one subsequent note on June 6, but no other mention throughout the rest of the volume.

Most "tumors" were swellings of inflammatory origin. A 4 year old boy had " a large tumour on the inside of his thigh — which is supposed to be the effect of the kick of another boy which happened about a month ago — at present ripe for opening. Let a seton be passed through it and applicet Cataplasm Saturnin . . . . . ." A week later we read "The Seton was introduced into the tumor on the 29th ult." (i.e., 2 days after the previous note) "which was followed by a copious discharge of thin carious mater notwithstanding the frequent application of Poultices and the internal use of the Peruvian Bark the margins of the tumor still continue hard and the matter discharged of a bad consistence. Since the introduction of the seton the Symptoms of a hectic fever have rather abated his appetite has increased at the same time. Pulse 80 — Belly bound." A few days later "All symptoms better bark agreed well with his stomach." And again after a few days "Pulse 100. Tongue clean belly bound Symptoms of Hectic disappearing and appetite better. Discharge of the Seton of a better consistence and hardness round the basis of the tumor subsiding." Improvement continued steadily over several weeks, but there is no notation of his being discharged cured.

There are a few fractures mentioned, but again only in sketchy fashion. One man "By a fall got a fracture about the middle of the Tibia with a wound of the teguments and considerable hemorrhage also a luxation of the top of the fibula." He was given a lotion, and also opium, but of his further course we are ignorant. We know only a little more about a Mr. Peden who had previously had a fracture and about whom there is only this one significant notation: "Finding the matter forming into Sinusses in the neighborhood of the fracture and the apperture not sufficient for the discharge it was dilated by a longitudinal incision extending an Inch above and below the fracture, and dressed with digestive and the eighteen tailed bandage, while he took internally the Peruvian bark to the extent of half a dram every 2 hours at present the callus seems to be forming apace, and the discharge from the incision of a good consistence and small in quantity, the eighteen tailed bandage has been omitted for some days by gone, in place of which a long linen roller is now applyed." Whether these cases recovered, or were later subject to amputation we do not know, but at any rate conservative treatment seems to have been the rule.

There is an excellent description of decubitus ulcers. A 23 year woman fell ill with an undetermined infection, characterized by shivering, headache, "Pain over her body", "petechial eruptions upon her skin" and "frequent loose bilious stools.". Under a variety of medications, principally Peruvian bark and tincture of opium, she improved, but sixteen days later, although the feverish symptoms had abated considerably, yet "owing to want of attention, in the people who had the care of her, a vessiccation of the cuticle has taken place in the Neighborhood of the Oss Sacrum, which rose into blisters containing a thin schorous matter, while the parts underneath seemed disposed to Gangrene, since which she has been using the fermenting Cataplasm frequently repeated to the parts affected, and has for these several days taken the Peruvian bark in half drachm doeses every 2 hours and Port wine to the extent of two* a day, by which means the gangrenous parts are beginning to separate from the Sound." After the lapse of one week more, "Symptoms of Pyrexia entirely gone, the remaining complaints are debility, and a gangrenous Ulcer upon the Oss: Sacrum which is now in a great measure separated from the sound parts." The cataplasm was continued. After another 10 days we learn that "The mortifyed part has sloughed off and the ulcer has a good appearance. Let it be dressed w^t Ung^t Basil Spread upon Lint."

COMMENT

The practice of medicine in Scotland, in 1787, as illustrated in this volume, has certain obvious defects. It is evident that history and physical examinations were, by our present standards, very rudimentary indeed, while the technical procedures which today we take for granted were at that time not known. There were no thermometers, no use of auscultation or percussion, very little even of palpation. With such limited methods of investigation it is no wonder that differential diagnosis was blurred. In the absence of discriminatory tools the patients were divided empirically according to symptoms, while the aim of treatment was to overcome the symptom. There was very little concept of disease en-

*At this point there is an illegible symbol.

tities or nosology. Only rarely was a definite diagnosis made, that is to say, only rarely did the physician lump together the various symptoms into a discrete recurring pattern to which he assigned a name.

But we need not be too critical of a bygone age when in our own era the same faults recur on a different level. Symptomatic treatment and failure to achieve a definite diagnosis are still all too prevalent today. A lack of critical analysis is still a fault, quite analogous to much of 18th century procedure.

The records herein described indicate a high degree of empiricism based on very sketchy observation, wherein superficial symptoms are combatted by drugs of unproven relevance. The practitioner worked under the assumption that a given drug or treatment, known to be beneficial in certain cases, will prove beneficial in *this* case. But today such an assumption is equally operative. Today, in spite of our techniques for fine discriminations, and our many exquisitely specific remedies, and in spite of our ideals of rational analysis, we still are largely empiricists. The practices of the 18th century, as recorded here, can make us wonder how our own histories, order sheets, and indications for operations, as found today in the average community hospital, will appear to the historian one hundred sixty seven years hence.

836 Wellington Ave.

‹‹‹ ›››

The last article

The periodic journals are not the only important kind of writing. Much of what is in a journal is crude and unsound. Only too often, many of us remain under the influence of the last article we have read, as a woman under the sway of the latest fashion. There is a difference between seasoned and unseasoned knowledge. So, it is well to have both kinds available. The shelves of our library must offer the greatest hospitality to a variety of subjects. Some books have written words of wisdom of the framework of the time in which they were written, but have ceased to be oracles. Some never had any important burden. Apart from any practical value of older writings, isn't it a pleasure to read the accounts of great discoverers in their own words and language and their problems? Many an ancient volume is of practical value and will grow old. There comes a time when every book in the library is wanted by somebody. *Louis Krause, M.D., The Library's Importance. Maryland M.J., Oct. 1954.*

New rickettsial infections

In psittacosis ornithosis, and lymphogranuloma venereum, the infectious agents are intermediate in size and until recently were classified with the smaller viruses. However, they are now classified according to Bergey's manual with the rickettsiae, so that the general group of the Rickettsiales includes not only the rickettsial forms but also the intermediate agents of the psittacosis-ornithosis-lymphogranuloma group. This reclassification has clinical implication in that the psittacine lymphogranuloma agents, as judged by their response to therapeutic substances, seem more closely related to the rickettsiae than to the smaller, true viruses. The smaller agents are now classified separately as Virales. *Russell J. Blattner, M. D. and Florence M. Heys, M. D., Host-Parasite Relationships In Virus Rickettsial Disease. Postgrad. Med. Oct. 1954.*

Diagnosis And Treatment of THYROIDITIS

ADOLPH KRAFT, M.D. & WILLIAM WOLF, M.D., Chicago

THE primary purpose of this report is to indicate the apparent increase in the number of diagnosed thyroiditis cases. This situation could be due to an increased interest and awareness of this pathological condition. This paper is concerned with the diagnosis and treatment of twenty-three cases of sub-acute thyroiditis which were observed during the years 1952 and 1953.

Sub-acute non-suppurative thyroiditis is the most common type of thyroiditis. This pathological condition may have a comparatively mild clinical course or may manifest itself as a severe acute febrile enity. Either case rarely requires surgical interference and as a rule both manifestations respond to medical management. Subacute non-suppurative thyroidits is an inflammatory condition of the thyroid gland and is usually self-limited in its involvement.

The exact etiology of sub-acute non suppurative thyroiditis is in question. The causative agent has been thought to either a bacteria or virus by various authors at various times.[1-6].

The majority of the cases of subacute thyroiditis complained of neck or throat pain which usually involve both lobes of the thyroid gland. However, on examination it may first involve one side and then as a rule, the pain involves the remaining lobe.

The generalized systemic symptoms usually vary with the severity of the individual case. Some patients will run a sever febrile course and others will manifest only a slight increase in temperature. Tachycardia was noted in 50% of the observed cases. Weakness in various degrees of severity occurred. Half of the cases appeared as mild hyperthyroid syndromes. The majority of the patients gave a history of previous episodes of naso-phagnitis, sore throats, tonsilitis or other various manifestations of upper respiratory infections.

Eight of the cases gave a history of having been using antibiotics for a variable length of time, prescribed for treatment of their upper respiratory infections. Weight loss and difficulty in swallowing were also common to the majority of cases.

Physical examination of the neck of these patients usually revealed a gland, which was very tender and enlarged, about 1½ times normal size. These glands, were for the most part firm and hard. It was noted that these glands will retain their normal shape and contour, which is not the case in malignancies or adenomas.

Unilateral swelling and tenderness did occur but it was the exception. There were usually no palpable lymph nodes in the neck or axilliae.

Laboratory findings in sub-acute thyroiditis. These cases were characterized by extremely low I^{131} uptakes (24 hrs). This is apparently uniformily so and in some cases the uptake may approach zero (24 hrs).

The BMR's were usually elevated and likewise the sedimentation rate. There seldom occurred an elevation in the WBC's. but an occasionally lymphocytosis was noted (6% of the cases showed a moderate lymphocytosis).

Treatment: The medical management of these 23 cases of thyroiditis was divided into three groups. The group I, II, III — were used to classify or group the cases according to the severity of pathology. This was employed so that an attempt could be made to keep the cortisone administration at the lowest optimun level.

Group I. Mild, little or no elevation of temperature. Moderately painful neck. No symptoms

Adolph Kraft Foundation Isotope Laboratory: St. Anne's Hospital, 4950 W. Thomas, Chicago, Illinois.

of hyperthyroidism. Low I^{131} uptake (24 hrs). Oral Cortisone 25 mgm tab. oral t.i.d. for a few days or until soreness of thyroid had been alleviated. Once that has occurred, or after the fourth day, whichever occurs first, then cortisone 25 mgm daily for 14 days. If symptoms tended to reappear after cessation of cortisone therapy, then the cortisone was continued, 25 mgm tab. daily for an additional 14 days. Aspirin gr v was given q.i.d.—Phenobarb. gr ¼ q.i.d. also was administered if patient showed undue anxiety. Ten patients treated in this manner responded well, 2 needed the second course of cortisone therapy. Three cases claimed relieve within 24 hrs. and 6 claimed symptoms were nonexistant after 72 hours.

Group II. Moderately severe: Temperature elevation 100 to 101.6; moderate tachycardia. Moderately tender thyroid. Symptoms of mild hyperthyroidism. Low I^{131} uptake (24 hrs.). Bed rest was employed whenever possible. Oral Cortisone tab. 25 mgm tab. i t.i.d. for 4 days. Aspirin gr v and Codeine gr 1/6 q 4 hrs. for 3 days and then Phenobarb. gr ½ q.i.d. was given for 5 days or until anxiety of patient ceased. After the fourth day, Cortisone 25 mgm tab. i daily for 14 days was administered. Eight patients in this group, 2 needed an additional 12 days of cortisone therapy. One claimed relief after 24 hrs. Three claimed relief after 72 hrs. One did not respond until the 12th day of treatment and 2 needed an additional 12 days of Cortisone therapy.

Group III. Temperature over 101.6, severe tachycardia symptoms of hyperthyroiditis. Severe pain over the thyroid, with considerable difficulty in swallowing. Low I^{131} uptake (24 hrs).

Hospitalization with Cortisone 200 mgm I.M. total first day dosage, 200 mgm I.M. second day total. 100 mgm I.M. 3rd and 4th days. Then Cortisone 25 mgm tab. i daily for 14 days. There were five patients in this group. Two patients became afebrile after 72 hrs., then after 96 hours ran a degree of temperature for 24 hours, then temperature free. Two patients became afebrile after 96 hours and remained afebrile. One patient became afebrile after 72 hours and remained temperature free until the 14th day and then was febrile with a low grade temperature for an additional 7 days. This patient received an additional 14 days of Cortisone 25 mgm Tab. i daily. He was temperature and symptom free following the second course of medication.

Twenty-three cases of non-suppurative thyroiditis were observed and treated with cortisone. The diagnosis of this enity was based on symptoms, physical and laboratory findings. The majority of cases gave a history of previous respiratory infections, usually associated with a sore throat. The majority of these patients had been or were still taking some form of antibiotics. All of the cases complained of a sore or tender throat to a varied degree. On physical examination, these cases showed either a uniform unilateral or bilateral tender enlargement of the thyroid gland. The cases that ran febrile courses were the most severe. More than 1/3 of the studied cases showed varying degrees of hyperthyroidism.

The most important laboratory finding was a decreased uptake of I^{131} (24 hrs.). The sedimentation rate of the erythrocyctes was as a rule elevated.

Leucocytosis was not a constant finding. Lymphocystosis was present in 10% of the cases.

Cortisone therapy was effective in relieving symptoms. Those cases which did not yield to the first course of medication were controlled by the second administration of this drug.

Cortisone as used in this series was well tolerated by the patients and no side reactions were observed.

The necessity for bed rest and larger doses of cortisone was governed by the severity of the pathology. All of these cases were given tracer doses of I^{131} for diagnosis. Follow-up tracer studies were employed after 10 weeks. Fifteen of these patients showed the uptake studies to be within normal limits. Five were slightly below normal and three were not available for tracer studies.

Other agents have been used in the treatment of thyroiditis. In seven cases thyroidectomies has been performed[7-8]. King[9] first used Thiouracil in treating acute thyroiditis. The use of x-rays[10] has been employed in the treatment of subacute thyroiditis.

Crile[11] and Clark[12] reported very favorably

on the use of cortisone on treating sub-acute thyroiditis.

Werner[13] treated 6 cases of sub-acute thyroiditis with ACTH & Cortisone. He concluded that ACTH or Cortisone therapy does not prevent the development of the spontaneous remission which customarily end the disease process. He further recommends ACTH and Cortisone as a satisfactory medication in treating this disease.

The mode of action in relieving symptoms in this disease enity are not clear at this time.

Pituitary adrenocorticotropin hormones have been shown to suppress inflammatory states and reactions. It has been postulated that Cortisone may suppress antibody formations, stimulate metabolic processes active and necessary in stimulating cellular response to infection—Cortisone may also act to affect peripheral vascular mechanisms controlling fluid loss through membranes. It has also been observed that adrenal steroids suppress thyroid actively through pituitary inhibition. This is accomplished by decreasing the secretion of the thyroid-stimulating hormone[14]. Further studies will undoubtedly aid in a better understanding of this physiological process.

SUMMARY

1. Twenty-three patients with sub-acute thyroiditis were given cortisone.
2. These patients were classified into three groups according to the severity of their symptoms and findings. The dosage of Cortisone was governed by the class or the severity of the disease.
3. The administration of Cortisone resulted in effective relief of the patient.
4. There were no side effects noted following the administration of cortisone.
5. Follow-up tracer studies with radioactive I^{131} indicated that the thyroid function returns to normal in a relatively short time.

REFERENCES

1. Ewing, J.: Neoplastic Diseases, ed. 2. Philadelphia, W. B. Saunders Co. 1922 p. 961.
2. Graham, H., and McCullagh, E. D.: Atrophy and Fibrosis Associated with Lymphoid in the thyroid. Arch. Surg. **22**:548-567 (April) 1931.
3. Womack, N.A.: Thyroiditis. Surgery **16**:770-782 (Nov.), 1944.
4. Marshall, S. F.; Meissner, W. A., and Smith, D. C.: Chronic Thyroiditis, New England J. Med **238**:758-766 (May 27) 1948.
5. Lee, C. H., Jr. and McGrath, E. J.: Struma Lymphomatosa Hashimotos Disease. Surg., Gynec. & Obstet. **76**:562-569 (May) 1943.
6. Wright, H. W.: Chronic Inflammatory Disease of the Thyroid Gland. New York State J. Med. **50**:2802-2806 (Dec. 1) 1950.
7. Clute, H. M. and Smith, L. W.: Acute Thyroiditis. Surg. Gynec. & Obstet. **44**:23-29 (Jan.) 1927.
8. Grile, G. Jr.: Treatment of Thyroiditis. Arch. Surg. **57**:443-449 (Oct.) 1948.
9. King, B. T. and Rosellini, L. J.: Treatment of Acute Thyroiditis with Thiouracil. J.A.M.A. **129**:267 (Sept. 22) 1945.
10. Osmond, J. D., Jr., and Portmann, U. V.: Subacute (pseudotuberculous, giant cell) thyroiditis and its treatment. Am. J. Roentgen **61**:826-829 June 1949.
11. Crile, G., Jr. and Schneider, R. W.: Diagnosis and Treatment of Thyroiditis with Special Reference to the Uses of Cortisone and ACTH. Cleveland Clinic Quart. **19**:219, 1952.
12. Clark, D. E.; Nelson, T. S., and Raiman, R. J.: Subacute Non-Suppurative Thyroiditis Treated with Cortisone. J.A.M.A. **151**:551, 1953.
13. Werner, S. C.: ACTH and Cortisone Therapy of Acute Non-Suppurative (Sub-Acute) Thyroiditis. J. Clin. Endocrinology **13**:1332, 1953.
14. Hill, S. R., Jr.; Reiss, R. S.; Forsham, P.H. and Thom, G. W.: The Effect of Adrenocorticotropin and Cortisone on Thyroid Function. J. Clin. Endocrinol. **10**:1375-1400 (Nov.) 1950.

Your Annual Meeting!

Chicago — May 17, 18, 19, 20

CASE REPORTS



Idiopathic Hypertrophic Pyloric Stenosis in an Elderly Adult

Harry W. Southwick, M.D., Danley P. Slaughter, M.D. and John A. Bollinger, M.D., Chicago

WHEN a patient of advanced years presents himself for examination and treatment with an incapacitating series of symptoms, more emphasis should be placed on Stewart's phrase[1] "too old not to be operated on" rather than the reverse and more familiar cliche. Elderly patients, like infants, do not have the physiologic reserve of the middle span of life, and if surgical management is possible, it should be offered as early in the course of the disease as the patient can be brought into a reasonably good (though generally temporary) nutritional state. In a number of instances, the disease may be a benign one, but its continued existence may result in the same fatality as though it were a malignant process. We offer the following case in point.

H. D. was 82 years old when she was admitted to St. Francis Hospital on December 23, 1951. The chief complaint at that time was abdominal pain accompanied by vomiting of two weeks' duration.

The patient gave a history of intermittent vomiting over the past three years usually accompanied by variable cramping pains. The vomitus was watery and green tinged, never containing any blood or coffee-ground material, so far as the patient could remember. In spite of medical management, her problem had been progressive gradually over the period of time and during the two weeks prior to admission she had been vomiting daily, though taking practically nothing by mouth. Her appetite during the preceding years had become progressively less acute, and she had lost 25 pounds in weight.

Fluoroscopic examination of the upper gastrointestinal tract had been undertaken six months previously with the finding of an annular deformity about 2 centimeters in length in the pyloric area. Operation was advised at that time, but the patient thought that she was "too old" and refused.

Bowel movements had been regular until the week prior to admission; during this time she

From the Department of Surgery, University of Illinois, College of Medicine, Chicago, Illinois, and St. Francis Hospital, Evanston, Illinois.

had passed no stool though the passage of a normal amount of flatus continued. There was no history of melena.

The patient admitted exertional dyspnea and some angina; moderate orthopnea existed requiring two pillows at night for sleep. Ankle edema had been present variably for five or six years. Her only previous surgical experience was an ancient appendectomy.

Physical examination at the time of admission revealed a markedly dehydrated, somewhat emaciated woman who appeared chronically ill. The blood pressure was 144/76, pulse 80, temperature 99.8 rectally. There was loss of turgor to the skin, the tongue was dry, red, and smooth. The lungs were clear to percussion and auscultation. The heart was slightly enlarged to the left, but the rhythm and rate were regular and no definite murmurs were heard. The abdomen was flat and bowel sounds were present and normal. No abnormal masses were palpable within the abdomen and no tenderness or pain was elicited on examination. Extensive varicosities were noted in both legs with pitting edema of both ankles. The reflexes were somewhat hypoactive.

The report of laboratory examinations after admission were as follows: hemoglobin 16.8 grams, red blood count 5.87 million, white blood count 12.650, nonprotein nitrogen 35.5 milligrams per cent, plasma chlorides 550 milligrams per cent, potassium 3.7 milli-equivalents per litre, and carbon dioxide 73 volumes per cent. A flat plate of the abdomen showed a normal amount of gas in the colon, but no distention of the small bowel.

A Levine tube was passed and the patient was placed on constant suction with adequate fluid and electrolyte replacement. Almost complete pyloric obstruction persisted, however. In spite of the patient's dehydration, the urinary specific gravity varied only from 1.006 to 1.010; there was consistently a trace of albumin in the urine.

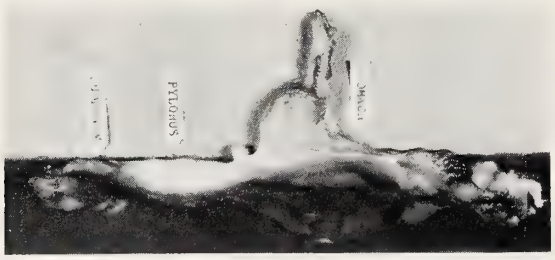


Figure 1—The specimen removed is shown in cross section. Note the marked thickening of the pyloric musculature. Microscopically, this proved to be a true muscle hypertrophy similar to that seen in infants.



Figure 2—The mucosal surface of the specimen was without ulceration or evidence of any neoplastic process.

After a transfusion of 500 cc of whole blood, the patient was operated upon on December 27, 1951. The abdomen was explored through an upper midline incision. There was a firm, smooth, fusiform mass occupying the pyloric area and obstructing the gastrointestinal tract at that point. Palpation revealed no evidence of ulceration or scarring of the duodenum or stomach, and no abnormal nodes were palpable. General exploration revealed no other abnormality. A resection of the involved area was selected as the most expeditious method of handling the problem, and this was completed with a Billroth I reconstruction. The abdominal wall was closed with interrupted through and through stainless steel wire and the skin was closed with interrupted cotton. The patient's postoperative course was surprisingly uncomplicated and she was discharged from the hospital on the fourteenth postoperative day taking a soft diet.

Grossly, the specimen revealed a marked thick-

ening of the pyloric musculature similar to but proportionately greater than that seen in infantile pyloric stenosis (Figures 1 and 2). There was no evidence of ulceration previously or at this time. The microscopic diagnosis was "hypertrophy and hyperplasia, pyloric muscularis with mild interstitial chronic inflammatory reaction." The patient was living and well two years after operation. She was then lost to follow-up.

DISCUSSION

Idiopathic hypertrophic pyloric stenosis is more uncommon than the existence of 71 case reports in the literature would lead one to suppose. The reason for this is twofold. In the first place, 23 of the cases lack microscopic confirmation of true hypertrophy of the pyloric musculature. In the second place, while some authors[2,3] emphasize a distinction between an idiopathic and concomitant type of lesion, others[4] lump them together as a single lesion. It seems to us that the only cases worthy of reporting are those unassociated with any other disease process, or confusion is bound to persist. The proximal hypertrophy of bowel wall associated with a stenosing lesion in the colon is not considered a separate disease entity, and the analogy found proximal to duodenal pathology we think is pertinent.

The etiology of the problem has never been understood completely, and consequently numerous theories have been advanced. Among these are an imbalance in the autonomic nerve stimuli to the musculature of the area[5], a chronic nutritional or electrolytic imbalance, with edema, etc. The more plausible explanation is the one which considers this disease to be a persistence of a minimal congenital lesion which has been in existence for many years prior to causing specific symtomatology.

The various forms of management have been capably covered in thorough reviews of the literature which have appeared within the past few years.[2,3] Medical management offers little relief of symptomatology and merely unnecessarily procrastinates definitive treatment. The "string sign" noted by Kleitch[4] is surprisingly constant and was present in our own case though we must admit our preoperative diagnosis in this elderly patient was that of a neoplastic disease. A more disseminated knowledge of the existence of the lesion postinfancy as well as the ability to recognize its roentgenological chracateristics will bring about a higher percentage of preoperative diagnoses and allow early surgical management.

SUMMARY

A brief summary of the diagnosis and management of idiopathic hypertrophic pyloric stenosis in the adult is presented. It is believed that it represents a persistence of the infantile congenital lesion in which symptomatology is minimal until later life. Correction of the deformity was obtained by a resection and Billroth I reconstruction.

An additional case of the disease in an 82 year old woman is added to the literature. This is the oldest patient on record with the disease who has been treated successfully.

BIBLIOGRAPHY

1. Stewart, J. D.: Editorial The Decon's Masterpiece, As The Surgeon Sees It., Annuals of Surgery **137**:143-144, 1953.
2. McCann, J. C. and Dean, M. A.: Hypertrophy of Pyloric Muscle in Adult., Surgery, Gynecology and Obstetrics **90**:535-542, 1950.
3. North, J. P. and Johnson, J. H., Jr.: Pyloric Hypertrophy In The Adult., Annals of Surgery **131**:316-329, 1950.
4. Kleitch, W. P.: Diagnosis and Treatment of Pyloric Hypertrophy In The Adult. Surgery **65**: 655-664, 1952.
5. Horton, B. T.: Pyloric Musculature, with Special Reference to Pyloric Block. American Journal Anatomy **41**: 197-226, 1928.

COOK COUNTY HOSPITAL CASE RECORDS



Fibrinolysis in Patients with Metastatic Carcinoma of the Prostate Gland

E. J. Dolaz, M.D., R. A. Dolehide, M.D. and I. A. Friedman, M.D., Chicago

REPORTS have appeared in the literature regarding observations of fibrinolysis in patients with metastatic carcinoma of the prostate gland.[1,2,3,4] A case is reported here because of the interesting manner in which our attention was first attracted to the presence of a hemorrhagic diathesis in the patient.

O. C., a 57 year old Negro was admitted to Cook County Hospital on April 23, 1954 with vague abdominal pains and leg pains of six months' duration. In addition there was progressive anorexia, malaise dyspepsia and weight loss. The patient had experienced increasing difficulty in walking for two months before admission and had become bedridden three days before admission. A week prior to admission there had been one episode of melena. There was no history of hemorrhagic disease, subjective or familial.

Examination. The patient was well developed, alert, and cooperative. He appeared anemic and chronically ill, had lost weight, and complained of severe leg pains.

Blood pressure was 170 systolic, 90 diastolic; pulse 72 and regular; temperature 98.6 degrees orally, and respirations 16 per minute.

Significant physical findings included pallor of the conjunctivae and pharyngeal mucosal surfaces; a firm, fixed left supraclavicular lymph node measuring 4 by 2 by 2 cm.; slight epigastric tenderness on deep palpation; and a slightly enlarged, smooth, firm, nontender prostate gland. The patient moved with difficulty during the examination, and palpation disclosed tenderness of the bones of the lower extremities, pelvis, and lumbar vertebrae.

Laboratory Data. Laboratory examinations performed shortly after admission revealed an essentially normal urinalysis. Stool benzidine was faintly positive. The hemogram showed a hemoglobin of 45 per cent (7.0 Gm.), red blood cell count 3.18 million, white blood cell count 6,650 with a differential of 61 neutrophils, 1 band, 21 lymphocytes, 6 monocytes, 11 eosinophils, and 5 nucleated red blood cells per 100 white cells counted. Red blood cell morphology

From the Hematology Laboratory and the Hektoen Institute for Medical Research of the Cook County Hospital, Chicago.

Aided by grants from the Olivia Sue Dvore and Edward Friedman Foundations.

demonstrated moderate anisocytosis, poikilocytosis and slight polychromatophilia and hypochromia. The platelet count was normal.

Impression. The original impression was gastric carcinoma with chronic blood loss.

An attempt at sternal marrow needle aspiration biopsy resulted in a dry tap. Iliac crest needle aspiration biopsy was then successfully performed. Cytologic examination of the smears obtained on aspiration biopsy of the iliac crest revealed cells appearing in syncytium, measuring from 5 to 15 micra in diameter, with light blue staining nongranular cytoplasm, containing large deep-staining nuclei and from 2 to 4 light blue nucleoli. Occasional cells demonstrating active mitosis were noted. The interpretation was that of marrow replacement with malignant metastatic cells, primary origin unknown.

A bleeding time test was performed because of profuse bleeding that occurred from the skin at the puncture sites for needle aspiration. This proved to be in excess of 35 minutes; clotting time, 11 minutes and 30 seconds which, according to the method of Lee-White, was within normal limits; prothrombin time was 23 seconds, with a control of 14 seconds; accelerator globulin level was 68.3 per cent of normal. Prothrombin consumption revealed a decreased utilization of prothrombin: 20 seconds at 1 hour. The result of the fibrinolysin test was positive, with beginning dissolution of the clot at 90 minutes and complete dissolution at 20 hours. The protamine sulfate titration was not revealing.

Chemical analyses revealed nonprotein nitrogen of 40 mg. per cent, total protein 7.2 per cent, alkaline phosphatase 16.4 Bodansky units (repeat, 16.0 Bodansky units), and an acid phosphatase of 46.1 Bodansky units (repeat, 21.0 Bodansky units). The chest and barium meal roentgenograms and the electrocardiogram were within normal limits. Roentgenograms of the vertebrae and pelvis revealed increased bone density of the ninth, tenth, and eleventh vertebral bodies, and increased areas of condensation in the pelvic bones suggestive of osteoblastic activity resulting from metastatic prostatic carcinoma. The supraclavicular lymph node was biopsied. Excessive bleeding was encountered on local excision, with difficult maintenance of hemostasis. Histologic examinations of tissue sections were compatible with lymph node metastases of prostatic carcinoma.

On the third hospital day, tenderness and swelling of the right knee developed. Approximately 25 cc. of gross blood was aspirated from the knee joint which did not clot after five hours. A platelet count on April 30, 1954 was again found to be adequate.

Diagnosis and Treatment. The diagnosis was metastatic carcinoma of the prostate, with circulating fibrinolysin. Stilbestrol therapy, 5 mg. 3 times daily, was instituted on May 1, 1954. Within a few days the patient who entered the hospital as a bed patient was able to walk about and was given bathroom privileges. Orchiectomy was refused. The patient was discharged for followup care on maintenance doses of stilbestrol.

Follow-Up Course. Progressive and increasing signs of congestive heart failure appeared during the ensuing two months after discharge. This was thought to be due to the contributing factors of anemia, arteriosclerotic heart disease, and sodium retention coincident with stilbestrol therapy. On June 27, 1954, the patient was readmitted. Coagulation mechanisms examined at that time revealed a normal platelet count, normal bleeding time and clotting time, and a negative fibrinolysin test. The prothrombin time was 17 seconds (control, 14 seconds), and the prothrombin consumption was still significantly abnormal. Stilbestrol was continued. Therapy for congestive heart failure was instituted, and the patient was again discharged on August 19, 1954. In November of 1954 the patient died in his home. Autopsy was not permitted.

DISCUSSION

Fibrinolysis is the dissolution of the fibrin clot of whole blood or plasma. It is detected by incubating a sample of clotted blood or plasma at 37 degrees C. and observing the disappearance of the clot. According to Tagnon,[5] fibrinolysis is present when the clot of whole blood or diluted plasma disappears completely in less than 24 hours at 37 degrees C.

Fibrinolysis is not a naturally occurring phenomenon, but has been reported in the blood of patients with hemorrhagic, traumatic, or surgical shock as well as burns, abruptio placenta, retained nonviable fetus, states of acute anoxia, after intravenous injections of antigens, parenchymatous liver impairment, pulmonary surgery,

disseminated carcinoma, and tuberculous infections.[1,6,7,8,9,10,11,12] In these conditions, although precipitating factors such as shock, anoxia, or excessive intravascular clotting invoke activation of profibrinolysin (plasminogen) into fibrinolysin (plasmin), Tagnon[1] believes that in carcinoma of the prostate, the mechanism of fibrinolysis may be different. It is probable that the prostatic cancer itself may have been the source of the enzyme responsible for the dissolution of the blood clot. Huggins and Vail in 1943 demonstrated such a fibrinolytic enzyme in prostatic tissue.[13]

The prostatic fibrinolysin, which is similar but not identical to plasmin, is not demonstrable in normal human serum, although it is possible that small amounts may escape into the circulating blood where they would be quickly neutralized by the serum antifibrinolysin and thus escape detection. In metastatic carcinoma of the prostate, the quantity of prostatic fibrinolysin released into the blood may be great enough to overcome the inhibitory action of serum and produce fibrinolysis. It has been shown that extracts of metastatic prostatic tissue also contain this proteolytic enzyme.[2]

The end products of fibrinolysis are no longer clottable by thrombin. This explains why fibrinolysis may result in the creation of a hemorrhagic diathesis. According to the data presented by Tagnon,[2] this proteolytic enzyme also digests accelerator globulin and prothrombin. These effects can produce a prolonged prothrombin time. In addition, fibrinolysis may produce bleeding even in the presence of normal blood fibrinogen level by promoting premature dissolution of the hemostatic blood clots at the bleeding sites before permanent repair has taken place.

Hemorrhagic manifestations of this fibrinolytic enzyme may be in the forms of epistaxis, melena, hematuria, hemarthrosis, purpuric phenomenon, or profuse bleeding following venipuncture or a surgical procedure; the manifestations may be insidious or abrupt and intractable.

In our patient it was of interest that with Stilbestrol therapy the bleeding time and fibrinolysin test result reverted to normal and the prothrombin time and prothrombin consumption approached the limits of normal. These effects also were observed by Tagnon[4] who states that this is another argument in favor of the thesis that the enzyme responsible for fibrinolysis originates in the prostate. No correlation between the level of acid phosphatase and the occurrence of fibrinolysis in patients with metastatic carcinoma of the prostate has been determined.

SUMMARY

1. A case of metastatic carcinoma of the prostate with hemorrhagic diathesis secondary to circulating fibrinolysin is reported.

2. Therapy with stilbestrol caused the fibrinolysin to disappear from the blood with subsequent correction of the bleeding time to normal, a negative fibrinolysin test, and improvement of the prothrombin time and prothrombin consumption, so that they approximate normal.

3. The physiologic actions of prostatic enzyme and fibrinolysin with its effects are reviewed.

1835 West Harrison Street

REFERENCES

1. Tagnon, H. J.; Whitmore, W. F., and Shulman, N. R. Fibrinolysis in Metastatic Cancer of the Prostate, Cancer, 5:9, 1952.
2. Tagnon, H. J.; Whitmore, W. F.; Schulman, P., and Kravitz, S. C. The Significance of Fibrinolysis Occurring in Patients with Metastatic Cancer of the Prostate, Cancer, 6:63, 1953.
3. Tagnon, H. J.; Schulman, P.; Whitmore, W. F., and Kravitz, S. C. The Hemorrhagic Syndrome of Metastatic Prostatic Cancer and Its Treatment, J. Clin. Investigation, 31:366, 1952.
4. Tagnon, H. J., Schulman, P.; Whitmore, W. F., and Leone, L. A. Prostatic Fibrinolysin, Study of a Case Illustrating Role in Hemorrhagic Diathesis of Cancer of the Prostate, Am. J. Med. 15:875, 1953.
5. Tagnon, H. J.; Levenson, S. M.; Davidson, L. S., and Taylor, F. H. L. The Occurrence of Fibrinolysis in Shock with Observations on the Prothrombin Time and the Plasma Fibrinogen During Hemorrhagic Shock, Am. J. M. Sc. 211:88, 1946.
6. Weiner, A. E.; Reid, D. E., and Roby, C. C. II. Incoagulable Blood in Severe Premature Separation of the Placenta, A Method of Management, Am. J. Obst. & Gyne. 66:3, 475, 1953.
7. Penn, S. R. and Walker, J. H. Defective Blood Coagulation Following Pulmonary Surgery, New England J. Med. 250:764, 1954.
8. Bennike, T. and Mullertz, S. Haemorrhagic Diathesis Associated with Fibrinogenopenia and Fibrinolysis, Acta Haemat. 8:147, 1952.
9. Ratnoff, O. D. Studies on a Proteolytic Enzyme in Human Plasma; VII. A Fatal Hemorrhagic State Associated with Excessive Plasma Proteolytic Activity in a Patient Undergoing Surgery for Carcinoma of the Head of the Pancreas, J. Clin. Investigation 31:5, 521, 1952.
10. Schneider, C. L. Abruptio Placentae After Fetal Death in Utero, Obstet. & Gyne. 1:3, 321, 1953.
11. Stefanini, M.; Campbell E. W.; Plitman, G. I., and Salomon, L. Coagulation Defects Due to Acquired Anticoagulants and Fibrinolysins, Their Detection and Treatment, Bull. N. E. Med. Center 15:23, 1953.
12. Stefanini, M. Fibrinolysis and "Fibrinolytic Purpura," Editorial, Blood, J. Hemat. 7:1044, 1952.
13. Huggins, C. and Vail, V. C. Plasma Coagulation and Fibrinogenolysis by Prostatic Fluid and Trypsin, Am. J. Physiol. 39:129, 1943.

EDITORIALS



Don't talk about the treatment

Treatment of obesity is hampered by the inherent psychological inadequacy of the patient. The usual low caloric diet, with or without drug supplements, leads to weight loss in the majority. But the results are likely to be temporary as these individuals tend to be long on appetite and short on will power.

A new psychological approach to insure patient adherence was suggested recently by J. C. Cohen, of Philadelphia.[1] The plan includes the usual procedures plus the factor of unobtrusiveness. He believes that persons of normal weight are tired of listening to the woes of their overweight friends. They dislike having the dietary problems of someone else paraded before them and frequently vent their annoyance by ridiculing or offering tempting tidbits to the portly. This attitude on the part of friends and acquaintances increases the obese person's craving for forbidden foods and makes it more difficult to stay on a diet.

Cohen tried out his theory on 27 men and women who had failed to respond to all previous therapy. Each patient was interviewed and told why it was necessary to lose weight. He emphasized the importance of the low caloric diet as a framework for reducing and made no attempt to curb the intake of a few of the most appealing foods. Ice cream and cake were permitted, for example, provided the individual practiced moderation.

The psychological aspect was explained also, along with the attitude of the person of normal weight on the subject of reducing regimens. A final warning was given the obese: "Don't talk about the treatment." A daily dose of 15 mg. amphetamine sulfate was prescribed in the sustained-release capsule.

All patients lost weight during the period of observation, which ranged from 4 to 39 weeks. Average loss for the group was 1.1 pound per week. The majority stated they experienced no difficulty in keeping the treatment secret until weight reduction became obvious. But they were warned not to volunteer any information; if they were questioned by the curious they were to be casual about the whole thing.

1. GP, Dec. 1954.

‹ ›

Research in gangrene

Wexler and Trycznki,[1] of Baxter Laboratories, found that their bacterial polysaccharide (Piromen®) was capable of preventing gangrene in rabbits. They immersed the ears of 62 rabbits in a freezing mixture (−50°C.) for one minute and then into a water bath heated to +42°C. for two minutes. Of these rabbits, 31 were given Piromen intravenously for 30 days; the remainder were used as controls.

Animals given rapid thaw therapy and Piromen recovered completely. Among the control groups, 32 per cent suffered no loss of exposed tissue by amputation but the ears were nonvital in appearance.

There is a need for drugs of this nature and we hope these experiments will be repeated, using more objective criteria to determine the results. Subjective evidence, such as the appearance of the tissues before and after, is open to criticism

1. J. Lab. and Clin. Med. Feb. 1955.

because it is determined through individual interpretation. Marked changes seldom are questioned but the significance of slight variations is too easily colored by prejudice, the desire to succeed, or by outside pressure.

‹ ›

The 1955 Annual Meeting

The 115th Annual Meeting of the Illinois State Medical Society will be held at the Hotel Sherman, Chicago, May 17-20, 1955. Arrangements for an outstanding meeting are well under way and we are able to publish a short synopsis of the program and other pertinent data in this issue of the Illinois Medical Journal. We will publish a more complete preliminary program in the April issue, and the official program in the May Journal.

We have arranged to go to press a week earlier for the May issue so that it will be in the hands of the membership of this Society a week or more before the meeting begins.

It is hoped that there will be a banner attendance at the 1955 Annual Meeting, and that all members of the Society will mark the date on their calendar so that the necessary arrangements may be made to permit them to spend profitably the four days at this Annual Meeting.

‹ ›

The treatment of chronic leukemia

While there is still disagreement as to the nature of leukemia, it has seemed to the writer that the observations of Maud Slye on her cancer mice strongly suggest a neoplastic condition. Doctor Slye experimented for years on a strain of mice particularly prone to carcinoma, and from time to time members of her mouse colony developed not cancer but leukemia or Hodgkin's disease.

The acute form of leukemia, while sometimes improved temporarily by various medications, invariably ends fatally. In over 50 years as a pathologist and internist the writer recalls but one patient, an elderly woman, whose blood picture beginning as that of an acute leukemia changed to a chronic form, an observation confirmed by examination by the late George Minot.

Of the chronic forms the writer has seen a good many, especially with the lymphocytic type, which under a variety of treatments, usually including X-ray or radium, lasted for ten or fifteen years, their victims often able to carry a normal load of work.

In 1936 John H. Lawrence began the treatment of patients with chronic leukemia with radioactive phosphorus and he has recently published the results of a 20 year study of 129 patients with chronic lymphatic leukemia and 152 patients with chronic myelogenous leukemia, 54 of whom had the phosphorous isotope only. Of those whose treatment began before phosphorus therapy was introduced many had X-ray treatment and in all these, complications which arose were treated by the standard methods of the day.[1]

As a preliminary to treatment with phosphorus isotope, P 32, the standard clinical and laboratory methods of study were employed including sternal punch biopsy when it was desirable to judge from examination of the bone marrow changes which might bear on future treatment. The history, the physical examination, especially the palpability of the spleen and the superficial lymph nodes, the blood picture, including red cell production rates and blood volume, were all carefully recorded. After 1936 the beneficial and untoward effects of the radiophosphorus treatment also were observed.

Tabulation of the results by graphic methods demonstrated that as compared to groups of cases recorded by other observers the patients treated with phosphorus isotopes lived longer. Those with lymphatic leukemia lived longer than those with the myelogenous type. Prior to phosphorus therapy patients were studied, sometimes for months, and were not treated unless there was an increasing leucocyte count, increasing anemia, or increase in the size of the spleen or lymph nodes. It was noted that the best results were obtained with small doses of P32, an average of 1 or 2 millicuries once or twice a week, given intravenously or orally, for four to six weeks and usually not repeated within 6 months. It was noted that too intensive treatment with P32 can cause bone-marrow depression. The remedy has the great advantage over spray X-ray that it never causes unpleasant reactions such as may be caused by X-ray treatment. Doctor Lawrence reports that Doctors Osgood and Seaman have been equally successful with the agent.

1. Lawrence, John H., The Treatment of Chronic Leukemia. Medical Clinics of North America, 38, 527, March 1954).

There is no doubt that this method of treatment in a valuable addition to the therapy of chronic leukemias. G.B.

‹ ›

The death of Mrs. Andy Hall

Mrs. Andy Hall died at the family home in Mt. Vernon on Thursday, February 3, 1955. Mrs. Hall had been in poor health for a number of years, and for more than three years had been confined to her bed. Anna L. Glazebrook was born in Jefferson County, Illinois, and in addition to her attending the schools in her home community, she attended Hayward Collegiate Institute then operating at Fairfield, Illinois. She taught school after her graduation, and was a teacher in Mt. Vernon public schools when she married Dr. Andy Hall in Springfield, on January 1, 1892.

Following his graduation from Northwestern University Medical School in 1890, Dr. Hall began to practice in Mt. Vernon. The entire 63 years of their married life were spent in Mt. Vernon where Dr. Hall is still active in practice. Dr. and Mrs. Hall have three physician sons, one of whom, Dr. Marshall Hall is in practice at Mt. Vernon with his father. Dr. Andy Junior is a specialist in St. Louis, and Dr. Wilford, a Brigadier General in the Army Air Force is currently stationed in Paris, France.

She also is survived by six grandchildren and two great grandchildren.

Mrs. Hall for many years was active in all community affairs, her church, P.T.A., Woman's Club, and for a number of years, as a member of the Board of Park Commissioners at Mt. Vernon. She was a teacher in the Sunday School of the First Baptist Church of Mt. Vernon, for many years. Mrs. Hall was always proud of the accomplishments of her husband and of the three physician sons, and their respective assignments.

It was a great disappointment to her that she was unable to attend the reception given to her husband on his 90th birthday, on January 8, 1955. She too, was 90 years old at the time of her death.

The thousands of friends of Dr. Hall and his family join together in their expression of sympathy for the loss of the wife and mother of an illustrious family.

Dinner meeting honors Roland R. Cross and state health department

The Illinois State Medical Society was host at a dinner party honoring Roland R. Cross, M.D., Director, Illinois State Department of Public Health and his department. The affair was held at the Leland Hotel, Springfield, Tuesday evening, February 8. More than 130 state officials and members of the State Legislature attended as guests of the Society, many of them with their wives.

Dr. Arkell M. Vaughn, as President of the State Medical Society, in welcoming the assembly, told of the close relationship over a long period of time between the State Health Department and the physicians of Illinois, working toward their mutual interest for the health of the people of the state. Dr. Vaughn introduced Dr. James H. Hutton, Chicago, who acted as the toastmaster.

Dr. Hutton, in his opening remarks, expressed the Society's wish to honor Dr. Cross and his staff. Among the prominent guests at the speakers' table was Lieutenant Governor John Chapman who represented Governor Stratton.

Highlights of the work relative to the activities of Dr. Cross and his department were related by Lieutenant Governor Chapman.

Attorney General Castle was among those introduced as was Dr. Andy Hall, Mount Vernon, who served a four year term as Director of the Health Department under Governor Louis L. Emmerson. Five years ago "Dr. Andy," as he is called, was chosen as the Physician of the Year by the American Medical Association. In his whimsical manner, "Dr. Andy" easily convinced those present that a man is not necessarily "old" at ninety.

Dr. Hutton recalled some of the early actions of the Illinois Legislature in dealing with bills designed to improve the public health. He referred to a number of Illinois physicians who served as members of the State Legislature, pointing out that in the late "1850s" one physician from St. Clair County, William H. Bissel, was elected to the office of Governor.

Dr. Hutton also recalled that at the Annual Dinner of the Illinois State Medical Society sixty years ago in the Leland Hotel, announcement was made of an action taken that day by the Legislature when they had passed a bill

that reduced number of cases of blindness in Illinois.

Dr. Vaughn, following Dr Hutton's talk, presented Dr. Cross with a framed testimonial, emblematic of the excellent work he has accomplished in his more than fourteen years as Director of Health under four governors, two Republican and two Democrat.

In his acknowledgement of the honor given him, Dr. Cross recalled some of the problems encountered in the field of public health and what had been accomplished in Illinois since the Department was organized in 1877. He referred to the steady improvement in mortality and morbidity statistics, the gradual increase in the longevity, and many other noteworthy achievements of general interest.

Dr. Cross said, so far as he knew, this was the first time a professional organization voluntarily arranged a special event to recognize publicly a department of State Government for a "job well done."

This address, together with the one presented by Dr. Hutton, will be published in an early issue of the Illinois Medical Journal.

Introduction of the family of Dr. Cross was a highlight of the evening. Mrs. Cross and their four sons were presented. Dr. Roland, Jr., is associate professor of urology at Northwestern University Medical School; Dr. James H. is assistant professor of clinical surgery, University of Illinois College of Medicine; Gilbert H. is in the Corporation Department of the Secretary of State's Office, Springfield, and the youngest son, Chauncey, is a dental student in Chicago.

Further tribute was given to the Illinois Department of Public Health when Baxter K. Richardson, Chief Administrative Officer, was presented with a framed certificate, acknowledging the exceedingly fine work carried on over the years to improve the health of the people of the state and for the genuine cooperation which has existed continuously between the Department and the medical profession of the state, represented by the Illinois State Medical Society. Presentation was made by Dr. Joseph T. O'Neill, Chairman of the Council of the Illinois State Medical Society.

Mr. Richardson, who has been attached to the Health Department for more than 35 years, is popularly known as "B.K." to thousands of physicians in Illinois. Mrs. Richardson was also introduced.

Persons in charge of the numerous departments under the direction of Dr. Cross were introduced. They represented many divisions and activities of a successfully operating State Department of Health.

The Illinois State Medical Society was proud to be host to the 300 persons present and is especially appreciative that more than 130 members of the State Legislature and state officials were guests at this testimonial dinner to honor Dr. Cross as head of one of the highly important sub-divisions of our State Government.

ANNUAL MEETING
ILLINOIS STATE MEDICAL SOCIETY
Hotel Sherman
Chicago
May 17, 18, 19, 20, 1955

The Committee on Scientific Work, composed of the officers of the Scientific Sections, has completed the general outline for the 1955 annual meeting of the Illinois State Medical Society scheduled for the Hotel Sherman May 17, 18, 19, 20.

The Executive Committee was elected at the committee meeting last November, and charged with the responsibility of preparing the scientific programs for the GENERAL ASSEMBLIES. The personnel is:

Chairman: Ralph H. Kunstadter
Vice-Chairman: Cornelius M. Annan
Secretary: Arthur T. Shima
Assistant Secretary: Franklin J. Moore

The general outline of the meeting has been set up as follows:

TUESDAY, MAY 17

In the morning:
- Section on Anesthesia
- Section on Eye, Ear, Nose and Throat
- Section on Obstetrics and Gynecology
- Section on Cardiovascular Disease
- Physicians' Association of the Department of Public Welfare (if this group desires to meet with the Society again this year).
- FIRST MEETING OF THE HOUSE OF DELEGATES

At noon:
- Luncheon for the Section on Anesthesiology
- Any other luncheon scheduled through this office desiring to meet on Tuesday noon.

In the afternoon:
- GENERAL ASSEMBLY in the Ballroom
- Section on Radiology at 3:30 p.m.

In the evening:
- PUBLIC RELATIONS DINNER
- Hospitality Hour at 9:00 p.m. in the Bal Tabarin

WEDNESDAY, MAY 18

In the morning:
- Women Physicians' Breakfast at 8:00 a.m.
- Section on Surgery
- Section on Pediatrics
- Section on Eye, Ear, Nose and Throat
- Section on Pathology
- Illinois Chapter, American College of Chest Physicians (if this group desires to meet with the Society again this year).
- Meetings of the Reference Committees of the House of Delegates at 10:00 a.m.

At noon:
- Luncheon for the Section on Surgery
- Luncheon for the Section on Pathology
- Luncheon for the Illinois Chapter, American Academy of Pediatrics
- Luncheon, Illinois Chapter, American College of Preventive Medicine.
- FIFTY YEAR CLUB LUNCHEON in charge of Dr. Andy Hall as chairman of the Fifty Year Club Committee

In the afternoon:
- GENERAL ASSEMBLY in the Ballroom
- Meetings of the Reference Committees of the House of Delegates at 3:30 p.m.

In the evening:
- THE ANNUAL DINNER honoring Dr. Arkell M. Vaughn, retiring President of the Society

THURSDAY, MAY 19

In the morning:
- Section on Allergy
- Section on Medicine
- Section on Dermatology
- Section on Preventive Medicine and Public Health
- Association of Blood Banks (If this group desires to meet with the Society again this year)

Any additional meetings of Reference Committees of the House of Delegates as needed.

At noon:

Luncheon for the Section on Dermatology

Luncheon for the Section on Allergy

Luncheon for the Section on Preventive Medicine and Public Health

In the Afternoon:

GENERAL ASSEMBLY in the Ballroom

SECOND MEETING OF THE HOUSE OF DELEGATES at 3:30 p.m.

In the evening:

Loyola Alumni Dinner

FRIDAY, MAY 20

In the morning:

CINEMATIC CONFERENCE

THIRD MEETING OF THE HOUSE OF DELEGATES at 8:30 a.m.

The meeting closes officially at noon on Friday, May 20th.

HOUSE OF DELEGATES

First Meeting — Tuesday morning, May 17, at 9:00 a.m.

Second Meeting — Thursday afternoon May 19, at 3:30 p.m.

Third Meeting — Friday morning, May 20, at 8:30 a.m.

Reference committees will meet on Wednesday morning and afternoon; if too much work is given to any one committee and additional meetings are necessary, Thursday morning will also be available.

All county societies are urged to mail copies of resolutions to be presented before the House of Delegates to the office of the Secretary, 224 South Main Street, Monmouth, as soon as possible so that members of the House can be given this material for consideration prior to introduction on the floor. All resolutions received early will be published in the Handbook for delegates.

OUT OF STATE GUEST SPEAKERS

Each section has been given the privilege of inviting an out-of-state guest speaker to appear before the meeting of that Section in the morning, and the same out-of-state speaker will be asked to present a paper before the GENERAL ASSEMBLY that same afternoon. This arrangement makes it possible for a busy physician to plan his attendance at the Illinois State Medical Society meeting for one full day. He is invited to spend as much time with us however, as his personal schedule will allow.

The officers of the Society have the honor and privilege of inviting the Orator in Medicine and the Orator in Surgery to appear before the GENERAL ASSEMBLY. These two scientific presentations and the President's Address are scheduled when no other official society function is going on.

GENERAL ASSEMBLY PROGRAMS

Dr. Ralph H. Kunstadter as chairman of the Executive Committee has announced the general outline of the ASSEMBLY meetings to be held on Tuesday, Wednesday and Thursday afternoons.

TUESDAY, May 17

Speakers will be

William B. Thompson, Associate Professor of Obstetrics and Gynecology at Stanford University, California

John Gillies, Director of the Department of Anesthesia, Royal Infirmary Edinburgh, Scotland

George Crile, Jr., Chairman of the Department of Surgery, Cleveland Clinic, Cleveland, Ohio

Wendell G. Scott, Associate Professor of Clinical Radiology, Washington University, St. Louis

Henry E. Michelson, Professor of Dermatology, University of Minnesota Medical School

Herman M. Burian, Professor of Ophthalmology, State University of Iowa Hospitals, Iowa City

WEDNESDAY, MAY 18

Speakers will be:

President's Address — Arkell M. Vaughn

Oration in Surgery — Alton J. Ochsner, William Henderson Professor of Surgery and Chairman of the Department of Surgery, Tulane University, New Orleans

Oration in Medicine — Thomas

Francis, Jr., Professor and Chairman of Epidemiology, Virus Laboratory, University of Michigan School of Public Health

Panel on Poliomyelitis

Julius H. Hess, Chicago, Moderator
Thomas Francis, Jr. Ann Arbor, Michigan
Howard J. Shaughnessy, Chicago,
Albert M. Wolf, Chicago, Michael Reese Research Foundation

Speakers on the Subject of Poliomyelitis:

Leonard M. Schuman, Associate Professor of Public Health University of Minnesota
Clifford Grulee, Jr., Assistant Dean, Pediatric Department Tulane Medical School, New Orleans

THURSDAY, May 19

Speakers will be:

Samuel M. Feinberg, Professor of Medicine, Northwestern University Medical School, Chicago

Robert Grissom, Professor of Internal Medicine, University of Nebraska College of Medicine

Keith Truemner, Rockford Memorial Hospital, Rockford

Max Samter, Associate Professor of Medicine, University of Illinois College of Medicine, Chicago

A. L. Aaronson, Assistant Professor of Medicine, The Chicago Medical School, Chicago

Marc Hollender, Associate Professor of Psychiatry, University of Illinois College of Medicine

Francis L. Lederer, Professor of Otolaryngology, and Chairman of the Department, University of Illinois College of Medicine, Chicago.

Preliminary program material has been received from several sections.

SECTION ON PEDIATRICS will have a combined meeting with the Section on Preventive Medicine and Public Health on Wednesday morning, May 18. Following the presentation of several individual papers the group will schedule A PANEL ON IMMUNITY AND ANTIBIOTICS. The Illinois Chapter of the American Academy of Pediatrics will have its annual luncheon on Wednesday noon.

THE SECTION ON PREVENTIVE MEDICINE AND PUBLIC HEALTH will meet Thursday morning, May 19. This group plans to present a PANEL ON SCHOOL HEALTH AND THE FAMILY PHYSICIAN, followed by individual papers presented by men well trained in the public health field. They will have a luncheon on Thursday noon.

THE SECTION ON DERMATOLOGY will meet on Thursday morning, May 19. This group plans a SYMPOSIUM ON CUTANEOUS MEDICINE, and also a PANEL ON THE "Management of the Superficial Fungus Infections". They will have a luncheon on Thursday noon.

THE SECTION ON ALLERGY will meet on Thursday morning, May 19. This section has scheduled A PANEL DISCUSSION on "The Symptomatic Therapy of Bronchial Asthma"

SECTION ON SURGERY will meet on Wednesday morning, May 18. Following the recess to view exhibits the group will hear a PANEL DISCUSSION ON GASTROINTESTINAL BLEEDING.

PUBLICATION OF PROGRAM MATERIAL

The preliminary program will appear in the April issue of the Illinois Medical Journal, and the final material will be published in the May number. This has been made possible through arrangements with the press to have the May issue of the Illinois Medical Journal in the mails before the 10th of that month.

Please mark your calendar now and make your plans to attend the 1955 annual meeting at the Hotel Sherman, Chicago, on May 17, 18, 19, 20. For hotel reservations write to Mr. Earl R. Benedict, Convention Manager, Hotel Sherman, Chicago. Give him the date and time of arrival, the type of hotel accommodations you desire, how long you plan to be in Chicago, and mention the fact that your reservation is for the annual meeting of the Illinois State Medical Society.

MEDICAL ECONOMICS



John R. Wolff, Chairman, Walter C. Bornemeier, Edward W. Cannady, Roland R. Cross, Jr., E. F. Dietrich, W. W. Fullerton, Edwin F. Hirsch, Frederic T. Jung, W. R. Malony, Caesar Portes, William Requarth, Frederick W. Slobe.

A Proposed Revision of the Coroner's Act of the State of Illinois

Edwin R. Hirsch, M.D., Chicago

THE Constitution of the State of Illinois, adopted in 1870, directed that every county shall elect a coroner for a term of four years but did not specify his duties and authority. The Coroner's Act of 1874 defined these duties and responsibilities. Since then the General Assembly has added the following sections to the Coroner's Act: 1) in 1881, three sections concerning coroner's deputies; 2) in 1907, a section on embalming bodies subject to coroner's investigation; 3) in 1909, a section on the removal of a body under investigation from a county; 4) in 1931, a section on inquests; 5) in 1933, two sections on witnesses; and 6) in 1941, a section on coroners in military service. None of these added sections gives specific instructions about the procedures for the necropsy of bodies where death has resulted or is suspected to have resulted from violence or unnatural causes. Accordingly, nothing has been done by direct revisions of the Act of 1874 to improve the quality of the medical examinations for the Coroners of Illinois when they are confronted with the problem of determining the cause and means of death in a body referred for investigation.

When the Coroner's Act was placed on the statutes by legislation in 1874, modern scientific aids (forensic pathology) had not been developed. Forensic pathology pertains to the use in courts of law and elsewhere of information gained by the gross, or microscopic or other examinations of tissues with medicolegal implications. It provides the facts by which criminal justice can be established, and by which claims for compensation can be judged. Because pathology has many roots of origin and uses methods prevailing in the basic biological and physical sciences of anatomy, histology, physiology, chemistry, physics, general biology and even botany, the knowledge and technics of any of these basic fields of science can contribute significant facts in the solution of a complex medico-legal problem. A careful necropsy may disclose tissues diseased or injured sufficiently to be the cause of death. From a level of such a direct procedure with definite conclusions can extend a series of increasingly complex examinations which only a scientist with the knowledge and the technic of a specific basic science can make and interpret.

An inclusive system of forensic pathology, therefore, should have pathologists trained in forensic medicine to make the necropsy examinations as well as the technical facilities for preparing histological sections of tissues. It should

have chemical and toxicological laboratories for the detection and quantitative estimation of poisons in tissues. It should be able to call upon experts for significant hematological and serological tests; scientists in biology, or in physics, or in botany, or on occasion in other specialized fields. Such a coordinated system with methods for collecting, preserving, and integrating factual data by records, imprints, photographs, charts, sketches etc., can be a powerful agent in the administration of criminal and social justice of a community.

The Institute of Medicine of Chicago, for many years, has urged legislative improvement of the old Coroner's Act of 1874, and more recently also the Chicago Medical Society and the Illinois State Medical Society have joined in this effort. The Illinois State Medical Society in 1952 appointed a committee to examine the possibilities of a constructive revision of the Coroner's Act which would give to the Coroners of Illinois in the discharge of their duties, the advantages of a system of forensic pathology. The members of this committee are Doctor Harlan English of Danville, Doctor C. Paul White of Kewanee, Doctors S. A. Levinson and Edwin F. Hirsch (chairman) of Chicago, and John Neal (legal advisor) of Chicago. More recently Doctor Franklin Moore of Chicago and Walter Oblinger (legal advisor) of Springfield were added. Toward the end of the Session of the Legislature in 1953, a bill was presented for hearing but was not introduced to either chamber for a vote. In the meantime, the Association of Coroners of Illinois also became interested in a revision of the Coroner's Act of 1874. Representatives from this group and members of the Committee of the Illinois Medical Society joined in discussions of ideas and concluded that the objectives of both groups could be consolidated into one bill.

Any legislative revision of the Coroners' Act must cover all counties of the State. To do this for the large State of Illinois and the great range of Coroner work-loads in counties, a division of counties on the basis of population was suggested. In the proposed bill, counties of more than 500,000 population are designated as Class I Counties, and those of not more than 500,000 population as Class II Counties. In cases referred to any Coroner, he will make a preliminary examination into the circumstances of the death and with the aid of a coroner's physician attempt to ascertain the cause of death, either by necropsy or other investigations. Necropsies for coroners will be performed by physicians duly licensed to practice medicine in all of its branches, and wherever possible by one with special training in pathology. In Class I Counties such medical examinations or necropsies shall be performed by physicians appointed or designated by the Coroner, and in Class II Counties by physicians appointed or designated by the Director of the Illinois Department of Public Health.

The proposed bill also defines more clearly the cases of death which belong to the jurisdiction of the coroner; it protects the coroner and the coroner's physician against civil or criminal liability in the discharge of their duties; and leaves with the county the cost of the examinations. The bill directs that a coroners jury shall be summoned in cases of apparent or suspected suicide, homicide or accidental death but in other cases at the discretion of the Coroner. This provision can eliminate many farcical jury hearings.

A companion bill provides that necropsy service to the Coroners of Class II Counties of the State of Illinois, be established in the Department of Public Health with an Advisory Board appointed by the Governor. Under this plan, coroner's physicians are designated by the Department of Public Health to cover regions of Class II Counties throughout the State. A coroner's physician covering a region of counties will be called upon for necropsy service by the coroners of such a region. The Advisory Board appointed by the Governor will have nine members, three of them licensed physicians, three of them duly elected Coroners, and three of them lay representatives with at least one from the legal profession and acquainted with forensic medicine. A modest appropriation for expenses connected with meetings of the Advisory Board is included.

The proposals of the bill revising the Coroner's Act are sound and beneficial. In effect they would mark the beginning of a constructive program in which forensic pathology can develop as a forceful aid to the Coroners of Illinois in

(*Continued on page* 162)

THE P. R. PAGE



P. R. director back

Our director of public relations, James C. Leary, is back on the job after a three or four month struggle with those arteries. "The doctors' disease" rubbed off on him, but he has made a satisfactory recovery and we are happy to have him back at the old stand — even some thirty pounds light. He says it's the hard way to quit smoking. However, the experience has been valuable. He is now an expert (1) on taking things easy, (2) the cost of illness, (3) the value of insurance, (4) the number of slats in venetian blinds and (5) the percentage of laboratory EKG and blood sample technicians with cold hands — also stethoscope and electrode temperatures.

Annual health progress awards

The council at its last meeting approved a set of rules for conferring the annual "Illinois State Medical Society Health Progress Awards."

One goes each year to a layman and an organization which has done an outstanding service to the public in a health field.

The award will be conferred at the annual dinner of the society during the annual meeting each May.

Nominations, together with corroborative data, may be submitted by any member, committee, or county society in the state society. They should be forwarded to Dr. Harold M. Camp, secretary of the Illinois State Medical Society, Monmouth, Illinois.

The selection will be made by The Committee on Medical Service and Public Relations, and reviewed for approval by the Council.

The Council emphasized that the awards are to be given to a layman or lay organization for service, not to the medical profession, but to the public. There is no other restriction on the scope of nominations.

Secretaries of county societies and others are invited to submit nominations immediately.

Coroner reform bills

By the time this is printed, a series of bills designed to improve the use of modern medical techniques in the investigation of deaths coming under the coroners' jurisdiction will have been presented to the General Assembly.

Details of these bills will be published to the medical profession by various means, and will not be examined here now.

However, these bills will need the support of medical and other scientific organizations of Illinois, if they are to pass. In their present form, they have been approved by representatives of the Illinois Coroners' Association as well as the Illinois State Medical Society. Such a background should minimize opposition.

Please do what you can to support these bills and to win for them the votes of legislators you may know.

CORRESPONDENCE



Woman's Auxiliary plans for Annual Meeting

The 1955 Convention for All Doctor's Wives, will be at the Sherman Hotel beginning Tuesday May 17, through Thursday May 19. The program will include doctors and other personnel of both State and National repute, who are well informed concerning vital health issues. Accepted methods of program presentation such as panels, films, and skits are to be used. The Wednesday morning program will be a "working session" where both the doctors and delegates participate in planning auxiliary work. This should be of vital interest to every doctor's wife who wants to be aware and properly informed concerning health problems that face the physicians and the means they have chosen to solve them.

Dr. John L. Reichert, an authority on child health, will answer questions regarding the film, How To Organize a Community Health Council. The panel called, Facts and Fallacies About the Medical Legislative Program will include Mr. James Leary, Public Relations Director of the Illinois State Medical Society; Mr. Joseph Stetler, representative for the legislative program of the American Medical Association; and one other authority, with Dr. J. L. Reisch, Councilor, as moderator.

The Speaker for the President's Luncheon on Thursday May 19, will be Dr. Alphonse McMahon, immediate Past President of the Southern Medical Association.

One of the highlights of our convention will be the Fashion Luncheon honoring the Past Presidents of the Auxiliary. It will be in the Sarah Siddon Room of the Ambassador East Hotel opposite the famous Pump Room. Surely no woman will want to miss this entirely lovely affair.

Every effort has been made to create a Convention Program that will be remembered as, enlightening, inspiring, and just plain FUN.

Inez Trumpé (Mrs. D. H.)
1955 Convention Chairman.

‹ ›

A course in the clinical pathology and pathology of parasitic diseases

A short intensive course on the laboratory diagnosis and pathology of parasitic infections will be presented August 15-27, 1955 at the Louisiana State University School of Medicine in New Orleans.

The course is designed primarily for pathologists and technologists. However, general practitioners, internists, pediatricians, gastroenterologists, and physicians engaged in the practice of public health and tropical medicine who are interested in the laboratory diagnosis of parasitic infections are welcome to attend. The instruction and training will be of assistance to pathologists who are preparing for board examinations, to pathologists and physicians who are responsible for the diagnosis of parasitic infections in their laboratories, and to technologists engaged in this specialty.

The course will include lectures, extensive demonstrations, films, and supervised individual laboratory study. Emphasis will be placed upon the practical aspects of laboratory diagnosis of common parasitic infections, including training in stool examination and stool concentration technics. Abundant material from patients with parasitic diseases endemic in this area will be available for examination. Comprehensive slide sets containing parasitic organisms in tissue

sections will be studied. Library facilities are available. The medical school building is air conditioned.

Registrants should bring their microscopes, equipped with mechanical stages, and their microscope lamps. A limited number of places will be available. The fee for the course is $50.00.

Persons interested in attending this course may write to:

Dr. Clyde Swartzwelder
Department of Microbiology
Louisiana State University School of Medicine
1542 Tulane Avenue
New Orleans 12, Louisiana

‹ ›

General practice lectures

The Illinois Academy of General Practice sixth annual postgraduate program resumes its spring series of six weekly, two hour lectures

Tuesday, April 12 at Joliet
Wednesday, April 13 at Alton, Chicago and Hinsdale
Thursday, April 14 at Belleville, Bloomington, Champaign, Danville, Effingham, Geneva, Herrin, Moline, Peoria and Rockford.
Friday, April 15 at Elmhurst

‹ ›

American Board of Obstetrics And Gynecology

The next scheduled examinations (Part II) oral and clinical for all candidates will be conducted at the Edgewater Beach Hotel, Chicago, Illinois, by the entire Board from May 12, through May 20, 1955. Formal notice of the exact time of each candidate's examination will be sent him in advance of the examination dates.

‹ ›

Annual meeting of American Goiter Association

The annual meeting of the American Goiter Association will be held at the Skirvin Hotel, Oklahoma City, Oklahoma, April 28, 29, 30, 1955. The program for the three day meeting will consist of papers and discussions dealing with the physiology and diseases of the thyroid gland. For further information and complete program, write to John C. McClintock, M.D., Secretary, The American Goiter Association, 149½ Washington Avenue, Albany, New York.

National Hospital Week

Each year the nation sets aside one week in which to become better acquainted with its hospitals. National Hospital Week in 1955 will be May 8-14. During this week the attention of the American public is focused on our hospitals, in which one out of every eight of us receives care each year. The theme of National Hospital Week in 1955 will be "Your Hospital. . . . A Tradition of Service."

National Hospital Week is sponsored annually by the American Hospital Association. Celebration of a National Hospital Day began in 1921 and was expanded to a week in 1953. National Hospital Week is traditionally built around the May 12 birthday of Florence Nightingale, the famous nurse crusader of the Crimean War, whose pioneer service led to the improvement of hospital care in both England and America.

‹ ›

Clinics for crippled children listed for April

Twenty two clinics for Illinois' physically handicapped children have been scheduled for April by the University of Illinois Division of Services for Crippled Children. The Division will count 15 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examinations along with medical social and nursing services. There will be 5 special clinics for children with rheumatic fever and 2 for cerebral palsied children.

Clinics are held by the Division in cooperation with local medical and health organizations, both public and pripate. Clinicians are selected among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or may want to receive consultative services.

The April clinics are:

April 5 — Quincy, Blessing Hospital
April 6 — Hinsdale, Hinsdale Sanitarium
April 12 — Peoria, Children's Hospital
April 12 — East St. Louis, Christian Welfare Hospital
April 12 — Flora, Clay County Memorial Hospital
April 14 — Springfield, St. John's Hospital
April 14 — Cairo, Public Health Building

April 14 — Elmhurst (Rheumatic Fever), Memorial Hospital of DuPage County

April 15 — Chicago Heights (Rheumatic Fever), St. James Hospital

April 19 — Danville, Lake View Hospital

April 20 — Alton (Rheumatic Fever), Alton Memorial Hospital

April 20 — Chicago Heights, St. James Hospital

April 21 — Rockford, St. Anthony's Hospital

April 21 — Watseka, American Legion Home

April 22 — Chicago Heights (Rheumatic Fever), St. James Hospital

April 26 — Peoria, Children's Hospital

April 26 — Effingham (Rheumatic Fever), St. Anthony's Hospital

April 26 — East St. Louis, St. Mary's Hospital

April 27 — Springfield (Cerebral Palsy), Memorial Hospital

April 27 — Elgin, Sherman Hospital

April 28 — Bloomington (General and Cerebral Palsy), St. Joseph's Hospital

April 28 — Mt. Vernon, Masonic Temple

‹ ›

Annual Otolaryngologic Assembly

The Department of Otolaryngology, University of Illinois College of Medicine, announces its Annual Assembly in Otolaryngology from September 19 through October 1, 1955. This Assembly will consist of two parts.

Part I. September 19 through September 24, 1955, will be devoted to surgical anatomy of the head and neck, fundamental principles of neck surgery and histopathology of the ear, nose and throat. This week will be under the personal direction of Maurice F. Snitman, M.D.

Part II. September 26 through October 1, 1955, will be devoted entirely to lectures and panel discussion of advancements in otolaryngology. The chairman of this section will be Emanuel M. Skolnik, M.D.

Registration is optional for one or both weeks.

‹ ›

"Prescription For Medical Partnerships"

"Prescription for Medical Partnerships," a general information booklet on the business details of establishing and continuing a group medical practice, has been prepared by Dr. Charles Maertz, retired Medical Director of The Union Central Life Insurance Company.

A copy can be obtained by writing to "Medical Partnerships," Field Service Division, P. O. Box 179, Cincinnati 1, Ohio.

‹ ›

Fracture course

The Philadelphia Regional Committee on Trauma of the American College of Surgeons announces a three-day Fracture Course by Dr. Lorenz Bohler, Vienna, Austria, and Dr. Jorg Bohler, Linz, Austria, on April 21, 22 and 23, 1955, at the College of Physicians of Philadelphia, 19 South 22d Street, Philadelphia 3, Pa. Each day's sessions will last from 9 A. M. to 12 noon and 2 P. M. to 5 P. M. The course will be supplemented with discussions by outstanding American fracture surgeons.

Reservations for the course will be strictly limited to 400. The fee for practicing physicians will be $50.00 and for residents, interns and medical students $25.00. Application blanks may be secured by writing to William T. Fitts, Jr., M.D., Secretary-Treasurer, Philadelphia Regional Committee on Trauma, 301 South 21st Street, Philadelphia 3, Pa.

‹‹‹ ›››

NEWS of the STATE

ADAMS

Annual Society Meeting.—About fifty physicians and their wives attended the annual social meeting of the Adams County Medical Society at the Elks' Club, January 17. Dr. Frank Brenner was chairman of the affair. Guests were Dr. Stanley and Dr. Martha Garstka, Clayton; Dr. and Mrs. A. S. Ash, Mendon, and Dr. and Mrs. Meyer Shulman, Pittsfield.

COOK

Branch Societies Present Heart Programs.—The Douglas Park Branch of the Chicago Medical Society, in cooperation with the Chicago Heart Association, covered the subject of "Heart Block" at its meeting, January 25. Participants were Drs. Aldo A. Luisada, associate professor of medicine, Chicago Medical School; Peter J. Beinar, clinical associate in medicine, University of Illinois College of Medicine; L. Feldman, clinical associate professor of medicine at Illinois, and James C. Havranek, assistant clinical professor of medicine at Stritch School of Medicine of Loyola University. On February 1, the North Shore Branch, in similar cooperation with the heart association, devoted its meeting to "Treatment of Congestive Failure". Speakers were Drs. David P. Earle, professor of medicine, Northwestern University Medical School, on "Action and Uses of Digitalis" and Ben I. Heller, assistant professor of medicine at Northwestern, on "Electrolytes and Diuretics."

Grant for Research.—The American Cancer Society, Illinois Division, has given $7,250 to the Hektoen Institute for Medical Research of Cook County Hospital for special research in the field of hematology concerning leukemia and other malignant diseases. The work will be conducted under the direction of Dr. Steven O. Schwartz, director of hematology at the Hektoen Institute.

The Hektoen Lecture.—DeWitt Stetten, Jr., associate director in charge of research, National Institute of Arthritis and Metabolic Diseases, delivered the thirtieth Ludvig Hektoen Lecture of the Frank Billings Foundation of the Institute of Medicine of Chicago, February 15. His subject was "Disturbances of Intermediary Metabolism in Diabetes Mellitus."

Hospital News.—Dr. Arkell M. Vaughn, President of the Illinois State Medical Society, was the guest speaker at the annual banquet and installation of officers at the Edgewater Hospital, February 12. Dr. Ira Schnaer was installed as president of the staff for 1955, and Dr. M. S. Mazel, medical director, presented a report of progress.

Society News.—Dr. Howard F. Polley, Rochester, Minn., addressed a joint meeting of the Chicago Rheumatism Society and the Chicago Society of Physical Medicine, February 23, on "Medical Management and Physical Treatment of Rheumatoid Arthritis."—The Illinois Society of Anesthesiologists was addressed, February 21, in the Children's Memorial Hospital Nurses' Home, by Harold R. Griffith, professor and chairman, department of anesthesia, McGill University Faculty of Medicine, Montreal, on "The Anesthesiologist as a Physician."—Dr. Raymond W. Waggoner, professor and chairman of the department of psychiatry, University of Michigan Medical School, will deliver the seventh lecture in the Fifth Annual North Shore Health Resort Lecture Series, April 6, on Treatment of Psychiatry; the title of the lecture will be "Value of Emotional Support and Environmental Manipulation."

Hospital Observes Twenty-Fifth Anniversary.—The silver anniversary of Little Company of Mary Hospital was observed, January 19, with a dinner in the Palmer House attended by approximately 1,000 persons. Cardinal Stritch and Mayor Kennelly spoke at the celebration. Six physicians who have been on the hospital staff since its opening received keys and trophies. They are Drs. Warren W. Furey, William Malone, E. D. Huntington, Anna Robinson, Roy M. Langdon and Edmund G. Lawler. Thirteen other physicians who joined the staff shortly after the opening also were honored. They are Drs. Frederick R. Bennett, Ralph E. Jones, Arthur W. Woods, Joseph M. Pape, Thomas A. Morrison, Leo P. A.

Sweeney, Paul E. Lawler, William W. Somerville, Stewart J. McCormick, William J. Hagstrom, Marshall D. Hayes, Louis Curry and Josiah J. Moore. Proceeds of the dinner will be used to help defray the cost of adding two floors to the hospital. With the addition, soon to be in operation, the hospital will have about 500 beds. Tickets for the dinner cost $100 a couple.

DU PAGE

New Officers.—Dr. Dan D. Jamison is now president of the DuPage County Medical Society; Dr. William E. Bretz, vice president, and Dr. Samuel K. Lewis, secretary-treasurer. Delegates to the Illinois State Medical Society are Drs. Armand J. Mauzey, Elmhurst, and Joseph R. O'Donnell, Glen Ellyn; alternates are Drs. David L. Olinger, Elmhurst, and William J. Berwanger, Glen Ellyn.

MCLEAN

Society News.—Recent meetings of the McLean County Medical Society were addressed by Dr. Douglas Morton, Elgin, on "Surgery of Cancer of the Head and Neck"; Dr. Milton Rauh, Springfield, on "Clinical Use of the Electroencephalograph," and Dr. Edwin C. Ernst, St. Louis, "Treatment of Carcinoma of the Cervix."

LAKE

Society News.—Mr. Edwin Holman of the Law Department of the American Medical Association addressed a joint meeting of the Lake County Medical Society and the local bar association, February 8, on "Medico-Legal Problems."

New Officers.—Dr. Douglas Boyd is president of the Lake County Medical Society; Dr. John Milroy, vice president; Dr. M. J. McAndrew, secretary, and Dr. Ray C. Johnston, treasurer.

MACON

Society News.—Dr. Louis M. Katz, director, department of cardiovascular research, Michael Reese Hospital, Chicago, addressed the Macon County Medical Society, January 25, in the Decatur Club on "Role of Diet and Hormones in Coronary Disease." In the afternoon he addressed a public meeting in Decatur on "What We Can Do in the Fight Against Heart Disease."

New Officers.—Dr. P. A. Steele was chosen president-elect of the Macon County Medical Society at a recent meeting and Dr. Maurice D. Murfin, Decatur, was installed as president. Dr. John W. Little, Jr. is secretary and Dr. Welland A. Hause, treasurer. Delegates to the Illinois State Medical Society are Drs. Murfin and C. Elliott Bell, and alternates are Drs. Edmund S. Lockhart and Charles F. Downing.

MADISON

Society Chooses New Officers.—Dr. Robert Anschuetz, Alton, was chosen president-elect of the Madison County Medical Society at a recent meeting, and Dr. Charles D. Ehlert, Alton, was installed as president. Other officers include Drs. Eugene F. Moore, Collinsville, secretary, and Leo H. Konzen, Wood River, treasurer. Delegates to the Illinois State Medical Society are Drs. Mather Pfeiffenberger, Sr., and Harry Mantz, both of Alton, and alternates are Drs. William Delicate, Edwardsville, and E. H. Theis, Granite City.

PEORIA

Physicians and Auxiliary Meet.—Elmer Hess, President-Elect of the American Medical Association, addressed the combined meeting of the Peoria Medical Society and its Woman's Auxiliary, February 8, on "This is Your AMA." Dr. Arthur Curtis, professor of dermatology, University of Michigan Medical School, Ann Arbor, addressed the society recently on "Recent Advances in Pigmentation."

KNOX

Society News.—Dr. Charles Paisley was installed as president of the Knox County Medical Society, January 21. Following the business meeting, Dr. Warren A. Clohisy, clinical assistant in surgery, Stritch School of Medicine of Loyola University, gave an interesting talk on "What's New in General Surgery".

ROCK ISLAND

Society News.—Dr. Alfred D. Biggs and Dr. Mila Pierce addressed the Rock Island County Medical Society at the Lutheran Hospital Nurses' Home, February 8, on the practical management of erythroblastosis.

SANGAMON

Second Memorial Meeting.—On January 6 the Sangamon County Medical Society held its second Memorial Meeting for three members who died during the past year: Drs. J. Shearl, M. M. Bradley and Robert Campbell. The Very Reverend Monsignor William J. Cassin conducted the services in St. John's Hospital. The three physicians had served their community for a combined total of 137 years.

Memorial Hospital Chooses New Officers.—On January 4, the following staff officers were elected at Memorial Hospital: Jacob E. Reisch, president; Harvey W. Sears, vice president, and Henry S. Bernet, secretary. Elected to the executive committee were Drs. Robert E. Bowen, Douglas M. Gover and Preston V. Dilts who in addition to the current officers and William W. Curtis, immediate past president, complete the personnel of this board.

Society News.—Dr. Arthur DeBoer, attending surgeon, Children's Memorial Hospital, discussed "Established Cardiac Surgical Procedures" before the Sangamon County Medical Society at the Elks Club, February 3, 1955.

Building Program Announced.—Additional types of service, increased diagnostic and treatment facilities and a nurses' residence are included in the expansion plans recently announced for Memorial Hospital. Under consideration at the present time are two seven-story wings, arranged in a V forma-

tion, to be added to the rear of the present structure, according to the Bulletin of the Sangamon County Medical Society. The plans include provision for about seventy-five additional beds, a new radiology department, a physical medicine unit, and a nurses' residence with accommodation for at least 100 nurses.

Approximately two thirds of the new beds will be used for the care of patients with chronic diseases and those with nervous and mental conditions. The remaining third will be in private rooms for medical and surgical patients.

Funds in the amount of $525,000 have been allocated by state and federal hospital authorities under the Hill-Burton Hospital planning and construction act to finance partially this building program. Memorial Hospital has just completed a $250,000 nursing education unit, which is described as the newest and most up-to-date facility of its kind in the state, if not in the entire nation, the bulletin reported.

VERMILION

Society News.—Dr. Harris B. Shumacker, Jr., professor of surgery, Indiana University Medical Center, discussed "Peripheral Vascular Disease" before the Vermilion County Medical Society in Danville, February 1. Dr. Max Sadove, Chicago, addressed a recent meeting of the society on "Thorazine."

WINNEBAGO

New Members.—On January 7, the four following applicants were accepted into membership in the Winnebago County Medical Society: Kenneth D. Skaar, a graduate of the University of Wisconsin Medical School; W. Donald Jones, a graduate of the University of Illinois College of Medicine; Charles S. Ballinger, a graduate of Harvard Medical School, and John L. Bacon, a graduate of the University of Maryland School of Medicine.

GENERAL

Lectures Arranged Through the Educational Committee of the Illinois State Medical Society:

Marvin A. Rosner, Edgewater Garden Culture Club in Chicago, January 19, on Common Gynecologic Problems in Women Between the Ages of 25 to 35.

Lawrence Breslow, Boone Parent-Teacher Association, in Chicago January 25, on Emotional Behavior of the Normal Child.

Arnold Wagner, Evanston, Newly Formed Class of Oldsters at the Community Church, Park Ridge, February 13, on Hygiene of Later Years.

Jerome T. Paul, Woman's Auxiliary to the Chicago Medical Society, March 8, on Summer Camps for Diabetic Children.

Charles I. Fisher, Chicago, Pekin Woman's Club, March 11, in Pekin on "Physical and Mental Hazards of Aging.

John F. Carey, Joliet, Steger Parent-Teacher Association in Steger, April 2, on Problems of Parenthood.

Jerome S. Beigler, Scammon School Parent-Teacher Association in Chicago, April 7, on Adult Mental Health.

Johann S. Bornstein, Chicago, Men's Club of the Thomas Congregational Church, April 15, on How Cancer Affects Smokers.

George L. Drennan, Jacksonville, Palmyra Grade School Parent Teacher Association in Palmyra, April 21, on Health of the School Child.

Lectures Arranged Through the Scientific Service Committee of the **Illinois State Medical Society:**

Warren A. Clohisy, Chicago, Knox County Medical Society in Galesburg, January 20, on "What's New in General Surgery."

J. C. Redington, Galesburg, Henry County Medical Society in Kewanee, January 12, on Case Finding in Tuberculosis.

Frederick Steigmann, Chicago, La Salle County Medical Society in Streator, February 10, on Diagnostic Considerations in Jaundice.

Joseph Sherrick, Chicago, Knox County Medical Society in Galesburg, February 17, on Cardiac Arrest.

Jerome S. Beigler, Chicago, Henry County Medical Society in Kewanee, March 9, on Psychosomatics of Hypertension.

W. Robert Elghammer, Danville, Iroquois County Medical Society in Watseka, March 15, on Preventive Pediatrics.

John L. Bell, Chicago, Whiteside-Lee County Medical Society, in Dixon, March 17, on Surgery of the Hand.

David E. Markson, Stock Yards Branch to the Chicago Medical Society, April 15, on Arthritis and ACTH.

Richard Allyn, Springfield, Montgomery-Macoupin County Medical Society in Litchfield, April 20, on The Nephritides: Anuria and Treatment.

William L. Riker, Douglas Park Branch to the Chicago Medical Society, April 26, on Surgical Emergencies in the Newborn.

"All About Baby" on WGN-TV.—Since the last issue of the Illinois Medical Journal, the following physicians have been seen on the telecast "All About Baby" on WGN-TV. All physicians appearing on the telecast are invited through the **Educational Committee** of the **Illinois State Medical Society:**

Bennett R. Sherman, member of the pediatric staff, St. Francis Hospital, Evanston, January 5.

Lawrence D. Elegant, member of the staff, Sarah Morris Hospital for Children, January 12.

John L. Archibald, member of the staff, St. George's Hospital, January 19.

Irving H. Rozenfeld, attending physician, Sarah Morris Hospital for Children, January 26.

Benjamin M. Gasul, director of cardiology, Cook County Children's Hospital, February 2.

Warren W. Schwartz, orthopedic surgeon, Children's Memorial Hospital, February 9.

Alfred B. Falk, attending dermatologist, Children's Memorial Hospital, February 16.

Meyer A. Perlstein, director, Children's Neurology Clinic, Cook County Hospital, February 23.

Postgraduate Conferences.—The **Postgraduate Education Committee** of the **Illinois State Medical Society,** in cooperation with the staff of the Veterans' Administration Hospital, Hines, presented a postgraduate conference at Kankakee, March 3, with the Kankakee County Medical Society acting as host. Speakers were Drs. Paul S. Reeder, "Abnormal Hemoglobins and Their Clinical Significance"; Joseph A. Powers, "Treatment of Spontaneous Pneumothorax"; Donald T. Foxworthy, "Reiter's Syndrome and Allied Conditions"; Frederick A. Lloyd, "Treatment of Urological Emergencies"; Edward O. Willoughby, "Management of Hypertension"; Ervin Kaplan, "Treatment of Lymphomas and Leukemias", and Bernard Edidin, "Differential Diagnosis and Treatment of Ulcerative Colitis"; Dr. W. J. Gillespy gave the evening address on "Surgical Lesions of the Pancreas". Dr. Charles P. Whalen, president of the Kankakee County Medical Society, presided at the evening session. Physicians attending the conference, together with their wives, were guests of Armour Laboratories Pharmaceutical Center at luncheon and a tour of inspection, preceding the conference.

The **Postgraduate Education Committee,** in cooperation with the faculty of Northwestern University Medical School, presented a similar conference in Jacksonville, March 10, with the Morgan County Medical Society acting as host. The program consisted of a panel discussion on massive gastrointestinal bleeding with the following participants: Drs. Clifford J. Barborka, "Medical Management"; Robert B. Lewis, "Radiodiagnostic Aspects"; Frederick W. Preston, "Surgical Therapy." A panel discussion on cardiovascular disease followed with Drs. Harold Laufman discussing "Present Day Surgical Management of Peripheral Vascular Disease", and Gilbert H. Marquardt, "Modern Concepts of Hypertension." The dinner speaker was Dr. Arthur DeBoer on "Surgery of Heart Disease."

Lilly Host to Students.—Members of the senior class of the Northwestern University Medical School and their wives visited Eli Lilly and Company January 9-11.

While guests of Lilly's they inspected the Lilly Research Laboratories and toured pharmaceutical, biological, and antibiotic production facilities.

Representing the school faculty with the group was Dr. Edward S. Petersen, director of medical clinics.

Horace A. Smith, Lilly representative in Chicago, accompanied the group to Indianapolis.

DEATHS

Gustav E. Brandle, retired, formerly of Chicago, who graduated at the Chicago College of Medicine and Surgery in 1915, died January 16, aged 77, in Hollywood, Florida, where he had been living for six years.

Ozro Bridge*, Chicago, who graduated at the University of Cincinnati College of Medicine in 1939, died in Zurich, Switzerland, January 12, aged 45.

Thomas J. Burke, Chicago, who graduated at Loyola University School of Medicine in 1926, died February 10, aged 59. He was a member of the staff of Mercy Hospital.

Harriet M. Day Chandler*, retired, Decatur, who graduated at the College of Physicians and Surgeons of Chicago in 1902, died December 3, aged 85, of cerebral thrombosis. She had practiced medicine in Decatur since 1909 until her retirement in 1951.

Evan H. M. Griffiths*, Chicago, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1909, died January 27, aged 68. He was one of the founders of West Suburban Hospital.

Linda K. Hutchins, Shannon, formerly of Freeport, who graduated at Northwestern University Woman's Medical School in 1899, died in December, aged 92.

George Austin Kerr, Chicago, who graduated at Jenner Medical College, Chicago, in 1910, died November 13, aged 78, of uremia. He was resident physician at the Bethany Sanitarium and Hospital.

Grant M. Kloster*, Oregon, who graduated at Northwestern University Medical School in 1931, died November 12, aged 63.

James Garfield Lamb*, Cerro Gordo, who graduated at the College of Physicians and Surgeons of Chicago in 1903, died December 8, aged 76. He was a member of the "Fifty Year Club" of the Illinois State Medical Society, and on the staffs of the John and Mary E. Kirby Hospital in Monticello and Decatur and Macon County Hospital in Decatur.

Edward Joseph Macdonald, Chicago, who graduated at the Chicago College of Medicine and Surgery in 1914, died December 26, aged 67.

Jerome B. Pusch*, Chicago, who graduated at the Chicago College of Medicine and Surgery in 1917, died January 22, aged 69. He was a violinist with the Professional Medical Arts Philharmonic Orchestra.

Harry Lee Shafer*, Cornell, who graduated at Jenner Medical College, Chicago, in 1915, died November 11, aged 67, of cardiac failure. He was past president of the Livingston County Medical Society and formerly county coroner.

Edward C. Spitze*, Champaign and East St. Louis, who graduated at Washington University School of Medicine in 1902, died recently, aged 80. He was a specialist certified by the American Board of Ophthalmology.

* Member of the Illinois State Medical Society.

Richard Charles Steffen, Chicago, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois in 1905, died December 2, aged 74, of arteriosclerotic heart disease. He was a member of the staff of the Illinois Masonic Hospital.

Dominico Sterbini*, Colfax, who graduated at Regi Università degli Studi di Roma, Facoltà di Medicina e Chirurgia, in 1920, died recently, aged 62.

Gustav F. L. Wedel*, Chicago, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois in 1908, died May 10, 1954, aged 76, of diabetes.

Carroll B. Welton, Chicago, who graduated at Chicago Homeopathic Medical College in 1899, died in Wesley Memorial Hospital, December 8, aged 78, of cancer.

Rebecca Miriam Yampolsky, Chicago, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1906, died in Los Angeles, October 24, aged 72, of coronary heart disease.

*Member of the Illinois State Medical Society.

Coroner's Act (Continued)

the discharge of their duties. Any constructive project in the health of a community must have a beginning. It does not realize full fruition without tedious effort, deliberation and time. Given these, results of great value can happen.

The members of the Illinois State Medical Society should give enthusiastic support to this legislation and should urge the senators and representatives from their districts to support these measures.

Trudeau School Of Tuberculosis

Despite the closing of the clinical facilities of the Trudeau Sanatorium, the 41st session of the Trudeau School of Tuberculosis will begin Wednesday, June 1st, and continue to June 29th.

The staff, facilities, and skills of the Trudeau organization laboratories, of the various sanatoria in the Saranac Lake area, and of the practising tuberculosis specialists of Saranac Lake will be called upon as in the past to present the program.

The course will cover all aspects of pulmonary tuberculosis and also certain phases of other chronic chest diseases, including those of occupational origin.

The schedule for the 1955 course is in preparation but copies of the program for 1954 are available.

Registrations will be limited and it is suggested that those planning to attend make early application for enrollment.

The tuition is $100, payable to the Trudeau School on or before the opening date, June 1, 1955. A few scholarships are available for those individuals who can qualify.

The Trudeau School of Tuberculosis has been approved for training of veterans under Public Laws and any applicant desiring to obtain veteran's benefits should clear his registration with the Veterans Administration before the session begins.

Applications and more detailed information may be obtained from: Secretary, Trudeau School of Tuberculosis, Box 200, Trudeau, New York.

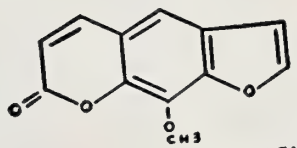
A NEW SECTION in your NOTEBOOK

In Vitiligo

OXSORALEN
(ELDER)

10 MG. CAPSULES
&
1% LOTION

Hyperpigmenting Agent



8-METHOXYPSORALEN

Send FOR CHEMICAL DATA AND PROFESSIONAL SAMPLE . . .

PAUL B. ELDER CO. BRYAN, OHIO

PAUL B. ELDER COMPANY
BRYAN, OHIO

BOOK REVIEWS

BABCOCK'S PRINCIPLES AND PRACTICE OF SURGERY: Edited by Carl C. Jonas, M.D., M.S., F.A.C.S.,-F.I.C.S. Lea & Febiger, Philadelphia, 1954. Price $18.00.

The new second edition of "Babcock's Principles and Practise of Surgery" written by Dr. Carl C. Jonas, who is associated with Dr. Babcock, is a new book in several senses of the term. This book of over 1500 pages and more than a thousand illustrations represents a new idea for a text book in surgery. It covers practically the entire field of surgery under the co-authorship of many other prominent men. Through this, the guiding principles of Dr. Babcock can be seen and he also has written several of the chapters. The book is very readable and is authoritative throughout.

Dr. Jonas has included all the late developments in surgery, showing the great impact of antibiotics upon surgical infections and tremendous advances in anesthesia and new frontiers that have been opened up, particularly in thoracic and cardiac surgery. Many recent innovations in abdominal and biliary tract surgery are brought out clearly and concisely, and new knowledge of the endocrine system is shown in excellent form. The text is concise as it would have to be in covering this wide range of subjects. However, it is specific and while it may primarily appeal to the students as a text to be studied in his medical school years, it is also a book which can be of great service to a practising surgeon because it gives him ready reference in a concise form of this entire field as a few other texts can do. It has the new very readable system of two column print which makes it less fatiguing than the older type of text book. The chapter on Military Surgery is alone worth the price of the book, particularly so considering the probable continued need of knowledge in this field. The surgery of children and congenital malformations also receive a separate chapter. Dr. Jonas shows his recognition of the importance of the blood chemistry and laboratory tests in diagnosis and treatment, and he has assembled a distinguished list of consultants whose background of teaching is such as to make this text one of unusual interest and value for both the student and practitioner of surgery. It is an up-to-date authoritative and easily readable value.—E.P.C.

‹ ›

UROLOGY; Volumes I, II, and III. Edited by Meredith Campbell, M.S., M.D., F.A.C.S., Emeritus Professor of Urology, New York University. With the collaboration of fifty-one contributing authorities. Publication date: September 28, 1954; Pages: 2,356 thru vols. 1, 2, and 3. Illustrations: 1,148 figs. thru vols. 1, 2, and 3. Price $60.00 per set. W. B. Saunders Company, Philadelphia.

This three volume compilation of truly classic monographs under the editorial direction of Dr. Meredith Campbell is a remarkable work.

This reviewer likes the arrangement of the subject materials. When one considers the tremendous volume of material that could be used, he is grateful that the monographs are adequate yet brief enough for rapid survey wheu needed.

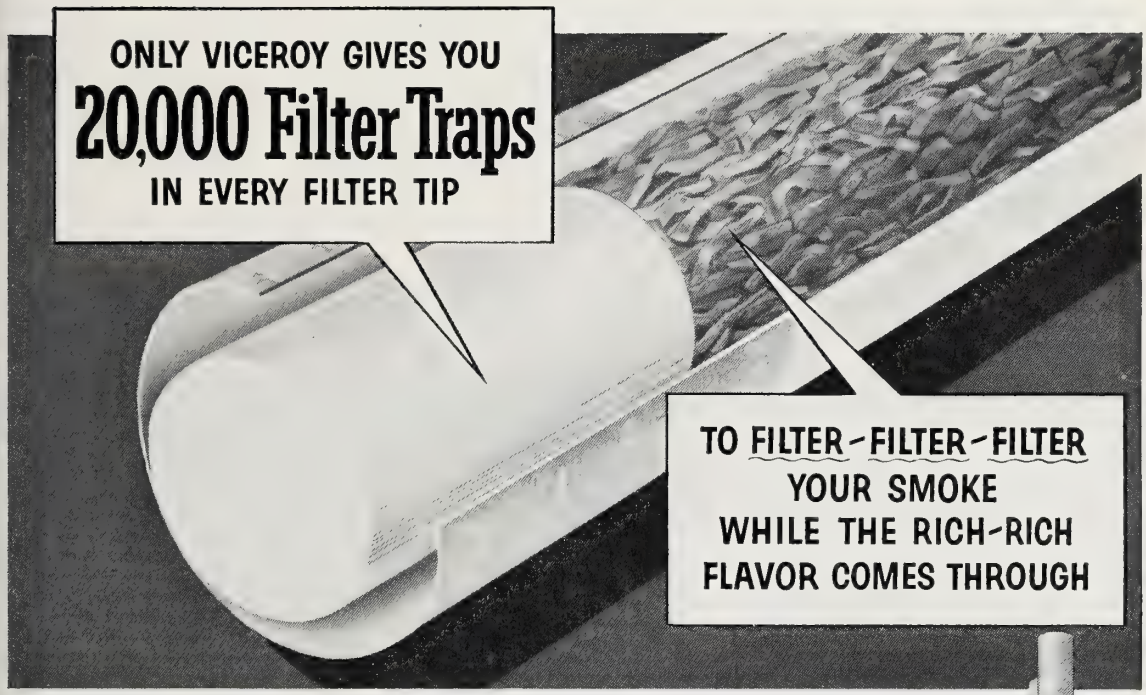
The section on "Anomolies of the Urogenital Tract" is excellent. The sections on "Neuromuscular Disease of the Urinary Tract" and

(*Continued on page* 66)



DOCTOR, here's a question and an answer you may find useful when patients ask about cigarettes:

What do Viceroys do for you that no other filter tip can do?



These filter traps, doctor, are composed of a pure white non-mineral cellulose acetate. They provide maximum filtering efficiency without affecting the flow of the smoke.

And, in addition, they enhance the flavor of Viceroy's quality tobaccos to such a degree that smokers report they taste even better than cigarettes without filters.

King-Size Filter Tip **VICEROY**

WORLD'S MOST POPULAR FILTER TIP CIGARETTE

ONLY A PENNY OR TWO MORE THAN CIGARETTES WITHOUT FILTERS



Book reviews (Continued)

"Tumors of the Urogenital Tract" are above reproach.

Those chapters on the various aspects of urological surgery are thoroughly yet briefly done. There are few wasted words.

Everyone will be impressed by the finest quality of illustrations this reviewer has ever seen, plus the easy readibility of the text.

This three-volume work can be recommended without hesitation for use by any practitioner of medicine and as invaluable text and reference volumes for any urologist.

The reviewer considers this a fine volume. The medical material is put together by outstanding collaborators. If hospital libraries were to have only one work on urolgy, this reviewer would recommend Campbell's three volume work.

H. E.

‹ ›

CLINICAL CHEMISTRY IN PRACTICAL MEDICINE: By C. P. Stewart, D. Sc. (Dunelm.), Ph.D. (Edin.), Reader in Clinical Chemistry, University of Edinburgh; Senior Biochemist, Royal Infirmary, Edinburgh, and D. M. Dunlop, B.A. (Oxon.); M.D., F.R.C.P. (Edin.), F.R. C. P. (Lond.), Christison Professor of Therapeutics and Clinical Medicine, University of Edinburgh; Physician, Royal Infirmary, Edinburgh. Fourth Edition. Edinburgh and London: E. & S. Livingstone Ltd., 1954. 320 pages. Price $5.00.

The Fourth Edition of this small book discusses the everyday application of biochemistry to clinical medicine. The contents include chapters on water and electrolyte balance; neutrality regulation; carbohydrate metabolism; tests of renal, hepatic, gastric, thyroid, and pancreatic function; plasma proteins; cerebral spinal fluid; calcium and phosphorus; hormone abnormalities; and nutritional deficiencies.

The evaluation of clinical chemical tests has become of increasing importance in medicine in the past thirty years. As we have gained knowledge about the biochemistry of disease, the number and complexity of chemical tests has increased. The field is still expanding rapidly. Every day reports of new procedures appear in the medical literature. It is not surprising that the practitioner, not closely associated with the laboratory, may occasionally be lost in a sea of conflicting results.

In order to avoid this unfortunate situation it must be kept in mind that biochemical examinations do not replace careful history taking and physical examination of the patient. The practitioner should be aware of the circumstances under which various chemical analyses may be of value, should know the interpretation and significance of the results, and should be well acquainted with the technique for obtaining specimens for the laboratory. He should have intimate knowledge of the simpler bedside laboratory tests and also a rather general acquaintance with other laboratory methods.

This book does not deal solely with either interpretation of chemical analyses or techniques. It includes some details about the tests which are considered more important and more reliable. The general emphasis is placed on the practical biochemical procedures in relations to practical clinical medicine. Yet it contains sufficient information to be of value for reference.

Because of this approach, the book can be recommended for any student or practitioner who is interested in chemical laboratory analyses and results.

J.C.S.

‹ ›

ANATOMY REGIONAL and applied by R. J. Last, M.D., B.S. (Adel), F.R.C.S., Professor of applied Anatomy, Royal College of Surgeons of England; Examiner in Anatomy for the Primary Fellowship Examination of the College; Examiner in Anatomy for the License in Dental Surgery of the College; Superintendent of Dissections and Past Examiner in Anatomy to the Examining Board in England; Examiner in Anatomy. Little, Brown & Company. Boston. Printed in Great Britain—$10.00.

The author attempts to explain the general principles that underlie the character of the various regions of the human body. The application to medicine and surgery of the knowledge gained as to these general principles is continually pointed out and it is with this meaning that the term "applied" appears in

(*Continued on page 70*)

against common intestinal flora



This sensitivity test shows ERYTHROCIN and the same antibiotics against a typical strain of *E. coli*. Note that ERYTHROCIN and penicillin do not affect growth of the organism—while the other antibiotics show marked inhibitory action. Since ERYTHROCIN is inactive against gram-negative organisms, it is less likely to cause alteration in common intestinal flora—with an accompanying low incidence of side effects.

...with little risk of serious side effects

One reason is because the drug acts specifically. It destroys coccic invaders, yet doesn't materially change the normal intestinal flora. Thus, side effects are rarely encountered with ERYTHROCIN. Nor does it cause the allergic reactions occasionally seen with penicillin. Abbott

filmtab*

Erythrocin® STEARATE

(ERYTHROMYCIN STEARATE ABBOTT)

*TM FOR ABBOTT'S FILM SEALED TABLETS. PAT. APPLIED FOR

·03111

specify

LEDERLE

POLIOMYELITIS IMMUNE GLOBULIN

(human)

Lederle

For the modification of measles and the prevention or attenuation of infectious hepatitis and poliomyelitis.

LEDERLE LABORATORIES DIVISION
AMERICAN Cyanamid COMPANY Pearl River, New York

Do You Know ? ? ?

THE SPECIAL DISABILITY PLAN

AVAILABLE TO MEMBERS OF

THE ILLINOIS STATE MEDICAL SOCIETY

Provides Benefits up to . .

$5000. ACCIDENTAL DEATH AND DISMEMBERMENT

$100. PER WEEK FOR TOTAL LOSS OF TIME as the result of either Sickness or Accident.
$15. DAILY HOSPITALIZATION for up to 90 days as the result of either Sickness or Accident.

Plus . . .

Optional 5 Year Sickness Coverage
No reduction in benefits because of other insurance
Full benefits to age 70 at same cost
(All Benefits Subject to Provisions of the Policy)

FOR ALL THE FACTS - - -
Write or Telephone

PARKER, ALESHIRE & COMPANY

175 W. JACKSON BOULEVARD
Chicago 4, Ill. **WAbash 2-1011**

Book reviews (Continued)

the title. The work is not on surgical anatomy and no operations are described.

There is much of the author's original work in this volume. Among the items included for example is the segmental innervation of the limb muscles, the movements of the knee joint and the control on the lateral meniscus exercised by the popliteus muscle, the role of the intrinsic muscles of the larynx, those of the mandible and of the floor of the mouth, and many others.

Dr. Last acknowledges quite humbly, with considerable appreciation the information which he has used, which was obtained from other scientists and from their records of work they have done.

The first section of the book gives a simple account of the nature of the tissues and structures that make up the body.

The following chapters then proceed in the consideration of the various regions of the body. In many instances, the technique of consideration is a bit unusual. For instance, the lower limb, is first shown and described in the general plan of the principles giving it its particular characteristics. Then the front thigh, next the adductor compartment, and then the gluteal and then the hamstring compartment, and the popliteal fossa. And then the book proceeds to the lower leg dealing with it in much the same fashion and this is just one instance.

There is in all regions an emphasis on general principles and from this, one understands why the structures are arranged as they are. Such consideration, when understood, tends to much better retention of the "Anatomy" of any part than does just factual memorization.

The book contains 665 pages including voluminous biographical notes and an adequate index. There are 309 illustrations, most of which were drawn by the author.

The book is well adapted to the use of students as well as for the physician in practice.

C.P.B.

‹ ›

He who has learned to disagree without being disagreeable has discovered the most valuable secret of a diplomat. *Bert E. Estabrook.*



Trasentine®-Phenobarbital

- Inhibits Parasympathetic Activity
- Relaxes Smooth Muscle Directly
- Exerts Local Anesthetic Effect on G-I Mucosa
- Sedates the Patient

Without Atropine Side Effects

Each tablet contains 50 mg. Trasentine hydrochloride and 20 mg. phenobarbital.
Also available: Trasentine hydrochloride Tablets, 75 mg.

Trasentine® hydrochloride
(adiphenine hydrochloride CIBA)



2/2061M

C I B A *Summit, N. J.*

BOOKS RECEIVED

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

DRUGS IN CURRENT USE 1955. Edited by Walter Modell, M.D., F.A.C.P., Associate Professor, Clinical Pharmacology, Cornell University Medical College. Springer Publishing Company, Inc., New York, New York. $2.00.

LEG ULCERS—Their Causes and Treatment. By S. T. Anning, T.D., M.A., M.D. (Cantab.), M.R.C.P., Assistant Physician, Dermatological Department, The General Infirmary of Leeds, Consultant Dermatologist, St. James' Hospital, Leeds, Clinical Lecturer in Dermatology in the University of Leeds. 42 illustrations. Little, Brown and Company, Boston, $4.00.

SIGNIFICANCE OF THE BODY FLUIDS IN CLINICAL MEDICINE. By Alexander Leaf, M.D., Associate in Medicine, Harvard Medical School, Assistant Physician, Massachusetts General Hospital, Boston, Massachusetts, and L. H. Newburgh, M.D., Emeritus Professor of Clinical Investigation, University of Michigan Medical School, Ann Arbor, Michigan. Charles C. Thomas, Springfield, Illinois. $2.50.

VIRAL AND RICKETTSIAL DISEASES OF THE SKIN, EYE AND MUCOUS MEMBRANES OF MAN. By Harvey Blank, M.D., Squibb Institute for Medical Research, Columbia University, University of Pennsylvania, and Geoffrey Rake, M.B., B.S., University of Pennsylvania, Wistar Institute of Anatomy and Biology, Squibb Institute for Medical Research. Foreword by Donald M. Pillsbury, M.D., University of Pennsylvania. 36 full color illustrations as 6 plates, 63 black and white illustrations, full color insert "Reactions to Smallpox Vaccination". Little, Brown and Company, Boston, Toronto. $8.50.

PUBLIC RELATIONS IN MEDIAL PRACTICE. By James E. Bryan, Administrator, Medical-Surgical Plan of New Jersey—formerly Executive Secretary, Westchester County Medical Society; Executive Secretary, New York County Medical Society; Executive Officer, The Medical Society of New Jersey; Chairman, Medical Society Executives Conference. Foreword by Louis H. Bauer, M.D., F.A.C.P., The Williams and Wilkins Company, Baltimore. $5.00.

DISEASES TRANSMITTED FROM ANIMALS TO MAN—Fourth Edition. By Thomas G. Hull, Ph.D., Secretary, Council on Scientific Assembly, Director, Bureau of Exhibits, American Medical Association. Charles C. Thomas, Publisher, Springfield, Illinois. $12.50.

FLORIDA'S HOSPITALS AND NURSES. By John Maclachlan, Ph.D., University of Florida Press, Gainesville. $1.50.

THE PHYSIOLOGICAL BASIS OF MEDICAL PRACTICE—A Text in Applied Physiology. By Charles Herbert Best, C.B.E., M.A., M.D., D.Sc. (Long.), F.R.S., F.R.C.P. (Canada), and Norman Burke Taylor, V.D., M.D., F.R.S. (Canada) F.R.C.S. (Edin.) F.R.C.P. (Canada). Sixth edition. The Williams and Wilkins Company, Baltimore, 1955. $12.00.

APPROXIMATE COMPARATIVE ANTITUSSIVE AND ANALGESIC DOSES OF OPIATES

1. To control cough 1/64 gr. Dilaudid is equivalent to 1/4 gr. codeine.
2. For analgesia 1/20 gr. Dilaudid will usually replace 1/4 gr. morphine or 1 gr. codeine. Dilaudid is given for pain relief, not for hypnosis.

• Dilaudid may be habit forming, and requires a narcotic prescription.

Dilaudid hydrochloride is available in various strength hypodermic tablets, in ampules, oral tablets and powder.

℞ in cough
Dilaudid HCl ... gr. ss
Elix. Terp. Hydr. ... ʒiv
One teaspoonful every 3 or 4 hours. Children half this dose.

Dilaudid®, brand of Dihydromorphinone, a product of E. Bilhuber, Inc.

Dilaudid
for pain and cough
BILHUBER-KNOLL CORP. *distributor*
ORANGE, NEW JERSEY



ELECTRON PHOTOMICROGRAPH

Escherichia coli 36,000 X

Escherichia coli ("colon bacillus") is a Gram-negative organism
commonly involved in
urinary tract infections and peritonitis,
and is an important etiologic agent of otitis media, mastoiditis, enteritis,
and septicemia in infants.

It is another of the more than 30 organisms susceptible to

PANMYCIN* HCl

TETRACYCLINE HYDROCHLORIDE

100 mg. and 250 mg. capsules
125 mg./tsp. and 250 mg./tsp. oral suspension (Panmycin Readimixed)

*TRADEMARK, REG. U.S. PAT. OFF.

Upjohn

Bed rest in the treatment of tuberculosis

A Statement by the Committee on Therapy of the American Trudeau Society, The American Review of Tuberculosis, June, 1954.

The continuing reports showing the increased effectiveness of antimicrobial therapy in the treatment of pulmonary tuberculosis have caused many physicians to question the necessity or advisability of prolonged bed rest.

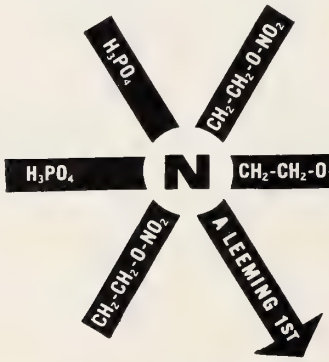
This has been further accentuated by the featured publication in newspapers and magazines of proposed clinical studies, although no such studies have in fact progressed to a stage which permits even preliminary conclusions to be drawn. Programs for the treatment of unhospitalized patients are frequently misnamed and misinterpreted as "ambulatory" treatment programs, as opposed to bed-care programs. In actuality, such programs are designed to supplement hospital care of patients, rather than to replace it by: (1) commencing antimicrobial therapy before hospitalization can be effected in communities where there is shortage of hospital beds; and, (2) continuing long-term drug therapy after control of the disease has been effected by hospital treatment. Even when home care is substituted entirely for hospital care by organized outpatient services, provision is made for bed care in the home. The designation of programs of this type as "ambulatory" presupposes an abandonment of the principle of rest therapy which is not intended and is not yet, at least, recommended by any official group.

The Committee again states that, from the facts now available, there is no evidence to support a reduction in the amount of rest therapy from that of past practices except as this may be justified by an earlier attainment of an inactive status of the disease. There appears to be no doubt that antimicrobial therapy has materially shortened the period of recovery in the average case of tuberculosis, and that it has greatly decreased the case mortality rate. This does not necessarily imply, however, that it has altered the indications for rest therapy during the active phases of the illness.

The studies which are in progress to determine to what extent bed rest may be safely dispensed

(*Continued on page* 82)

To prevent attacks and restore calm in Angina Pectoris



METAMINE, the new long-acting nitrate with the lowest dose and least side effects, is now available with butabarbital, widely accepted intermediate sedative. METAMINE *with* BUTABARBITAL prevents angina pectoris attacks and provides "therapeutic relaxation" to help the patient adjust to a level of activity within his limitations. DOSE: Swallow 1 tablet after each meal and 1 or 2 at bedtime. Vials of 50 tablets.

unique amino nitrate

NEW: **Metamine**® (2 MG.) **with**
triethanolamine trinitrate biphosphate, Leeming
Butabarbital (¼ GR.)

Thos. Leeming & Co. Inc. 155 E. 44th St., New York 17, N.Y.

medicine! heap good taste!

AUREOMYCIN SYRUP

Many a young Indian has taken his medicine and liked it because the doctor specified AUREOMYCIN CALCIUM SYRUP, a mildly sweet suspension with a delicate lime flavor.

Its potency of 125 mg. per teaspoonful (4 cc.) enables you to prescribe a specific dose to fit the patient—one which the parent can administer with accuracy. The syrup retains its potency for a year, and needs no refrigeration.

Long, widespread use has proved AUREOMYCIN to be a well-tolerated, broad-spectrum antibiotic promptly effective against a great variety of infections. Next time the patient is a young and wild one—remember AUREOMYCIN SYRUP!

Dosage forms for every medical requirement.

EOMYCIN*

Chlortetracycline *Lederle*

LEDERLE LABORATORIES DIVISION *AMERICAN Cyanamid COMPANY* PEARL RIVER, NEW YORK

Lederle

*REG. U. S. PAT. OFF.

For optimum results
in teen-age
dysmenorrhea

always prescribe
2
Edrisal* tablets
per dose



Smith, Kline & French
Laboratories, Philadelphia

Each 'Edrisal' tablet contains 'Benzedrine' Sulfate (racemic amphetamine sulfate, S.K.F.), 2.5 mg.; acetylsalicylic acid, 2½ gr. (0.16 Gm.); phenacetin, 2½ gr. (0.16 Gm.). Available on prescription only.
*T.M. Reg. U.S. Pat. Off.

Tuberculosis (Continued)

with, or in what categories or stages of the disease it may play an unimportant role in therapy, will require a long period of study. Until these studies are completed, the clinician will be well advised to adhere to the established indications for bed care. Essentially, these consist of relatively complete bed rest in accordance with previously accepted principles, until all symptoms have cleared, all cavities have been lost to view roentgenographically, all regressive infiltrations have reached an unchanging status, and sputum or gastric washings have become negative for tubercle bacilli by direct examination and culture. From this stage, gradual physical rehabilitation by progressive mobilization of the patient is permitted and is usually so graded to restore him to relatively normal activities no sooner than in six to twelve months. The total period of disability, although greatly shortened on the average, must still be estimated even in relatively mild and favorably responding cases as a minimum of one year. Even after this, the usual protective restrictions as to character and hours of work and the avoidance of strenuous exertion or fatigue must be observed for at least several years. The continuation of antimicrobial therapy itself for a total of one and one-half to two years is commonly recommended, but information is not yet available with respect to whether this provides adequate protection to permit any shortening of the convalescent period.

The indications for rest therapy during the active phases of tuberculosis are not altered by the proposals that patients may subsequently be treated with either surgical collapse or resection. A preliminary period of bed rest, combined with antimicrobial therapy, until all symptoms have cleared, cavities have diminished in size, or remain unchanged, and infiltrations have reached a relatively unchanging status is suggested. A continued period of rest after the surgical therapy is completed until it is evident that sputum or gastric washings will become and remain negative by culture and that the patient by symptom free should be used. From this stage, gradual physical rehabilitation for a period of several months, with the usual further protective restrictions, is indicated.

(*Continued on page* 84)

When infection complicates the picture



Exclusive

Terra-Cortril*

topical ointment

a clear-cut therapeutic answer

provides coordinated anti-infective, anti-inflammatory action quickly resolving inflammatory conditions in which infection is actual, suspected, or anticipated.

supplied: in ½-ounce tubes, containing 3% TERRAMYCIN® (oxytetracycline hydrochloride) and 1% CORTRIL® (hydrocortisone, free alcohol) in an easily applied ointment base.

*brand of oxytetracycline and hydrocortisone

Cortril Topical Ointment
Cortril Tablets
Cortril Acetate Ophthalmic Ointment
Cortril Acetate Aqueous Suspension for intra-articular injection
Terra-Cortril Ophthalmic Suspension

Pfizer

PFIZER LABORATORIES, *Brooklyn 6, New York*
Division, Chas. Pfizer & Co., Inc.

Miami Heart Institute

A non-profit Cardio-vascular Center
Endorsed by Florida Heart Association

Accommodations for
ambulant patients and guests

Recreation—Research—Rehabilitation

Staff open to Dade County
Medical Association

4701 N. Meridian Avenue,
Miami Beach, Fla.

On Beautiful Surprise Lake.

THUMBSUCKING

since infancy caused this malocclusion.



THUM TRADE MARK

THUM broke the habit and teeth returned to normal position.

ACCEPTED FOR ADVERTISING IN PUBLICATIONS OF THE AMERICAN MEDICAL ASSOCIATION

Get Thum at your druggist or surgical dealer.
Prescribed by physicians for over 20 years.

Mercy Hospital Institute of Radiation Therapy

The Henry Schmitz Medical Group

For Appointment
Victory 2-4700, Ext. 170 or RAndolph 6-4444

Herbert E. Schmitz, M.D., *Director*
Peter A. Nelson, M.D., *General Oncology*
Henry L. Schmitz, M.D., *Internal Medicine*
Janet Towne, M.D., *Gynecology*
Robert L. Schmitz, M.D., *General Surgery*
John F. Sheehan, M.D., *Pathologist*
Charles J. Smith, M.D., *Gynecology*
Charles S. Gilbert, M.D., *Internal Medicine*
William F. Cernock, M.D., *Internal Medicine*
Fred W. Eims, *Physicist*
Miss Hilda Waterson, R.N.
Helen Hansen, *Social Service*

COMPLETE TUMOR THERAPY
Including
SUPERFICIAL X-RAY THERAPY
DEEP X-RAY THERAPY up to 1,000 K.V.
RADIUM THERAPY

Daily Consultation at Institute
Tumor Clinic—Mercy Free Dispensary—Tuesday at 9 a. m.
Tumor Conference — J. B. Murphy Auditorium — Friday at 1 p. m.

Tuberculosis (Continued)

Robert L. Yeager, M. D., Robert A. Goodwin, M.D., Edward F. Parker, M.D., Carl Muschenheim, M.D., Paul T. Chapman, M.D., Morris C. Thomas, M.D., Roger Mitchell, M.D., Raymond F. Corpe, M.D. Robert H. Ebert, M.D., Chairman. Committee on Therapy, American Trudeau Society.

‹ ›

1954 statistics

The lowest death rate in the history of the country and the largest annual number of births were forecast for 1954 by Dr. Leonard A. Scheele, Surgeon General of the Public Health Service of the U. S. Department of Health, Education, and Welfare. Dr. Scheele made his statement on the basis of vital statistics reports for the first 10 months of the year.

The death rate for the year is expected to close at 9.2 deaths per 1,000 population, a substantial drop from the rates of 9.6 or 9.7 which have prevailed over the past five years. The absence of any reported outbreak of influenza in 1954, with consequent low death rates for the chronic cardiovascular diseases, was cited as a principal reason for the decline. Infant and maternal deaths were also expected to hit new lows.

Births will top the 4-million mark for the first time, according to preliminary estimates. The expected birth rate of 25.2 per 1,000 population is the second highest in 28 years, and only 5.3 percent below the peak year of 1947. A continuing rise in the births of third, fourth, and fifth children is probably responsible for the birth increases in 1953 and 1954. No increase in births of first children was expected because of falling marriage rates since 1951.

The marriage rate sank to 9.2 per 1,000 population in the first 10 months of 1954, compared with 9.7 for the same period the year before. Low birth rates during the 1930's, resulting in relative scarcity of young people of marriageable age in the present decade, were held chiefly responsible for the marriage decline.

Divorces in the first 9 months of 1954 were down 4 percent from the comparable 1953 period, on the basis of reports from 25 areas. Since the 1946 peak, divorce rates have dropped over 40 percent.

Single Tablet Combination Therapy in Hypertension

REATER EFFICACY
FROM SMALLER
DOSAGE

E ACTIONS FEWER
ND OF LESSENED
INTENSITY

IO COMPLICATED
SAGE SCHEDULES

IMPLER PATIENT
MANAGEMENT

RAUWILOID® + VERILOID®

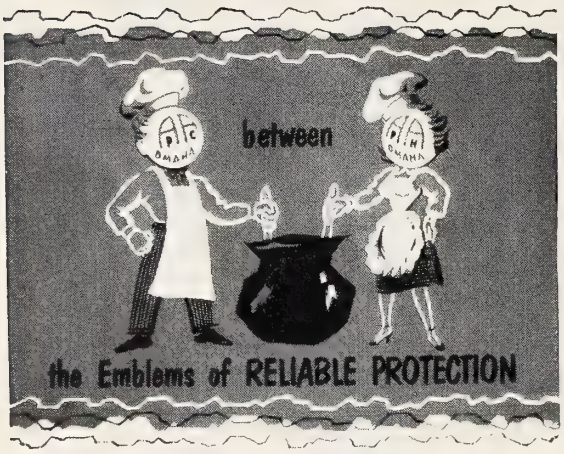
Indicated in moderately severe hypertension and in cases not responding to Rauwolfia alone. The combination containing Rauwiloid 1 mg. and Veriloid 3 mg. permits better tolerated doses of Veriloid to exert full hypotensive effect and leads to rapid symptomatic relief, while the contained Rauwiloid provides a tranquil sense of well-being. Initial dose, 1 tablet t.i.d., p.c. In bottles of 100.

RAUWILOID® + HEXAMETHONIUM

When ganglionic blockade is called for in rapidly progressing, otherwise intractable hypertension, Rauwiloid + Hexamethonium (each tablet containing 1 mg. Rauwiloid and 250 mg. hexamethonium chloride dihydrate) serves with greater efficacy and greater safety. The combination provides smoother, less erratic response to hexamethonium and permits greatly reduced dosage of the latter drug (up to 50% less). Initial dose, ½ tablet q.i.d. In bottles of 100.

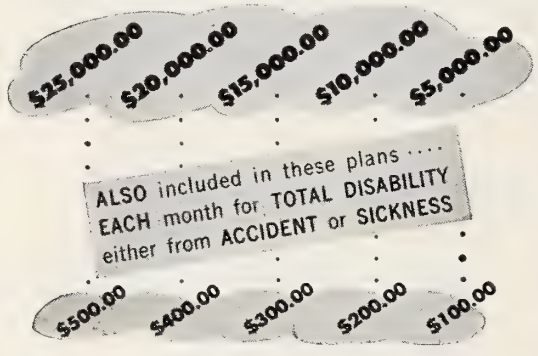
Riker LABORATORIES, INC., LOS ANGELES 48, CALIF.

Something NEW is Cooking



MORE INSURANCE NOW AVAILABLE

think! HOW THESE AMOUNTS WOULD HELP IN PAYING ESTATE TAXES IN CASE YOU ARE ACCIDENTALLY KILLED . . .



SPECIFIC BENEFITS ALSO FOR LOSS OF SIGHT, LIMB OR LIMBS FROM ACCIDENTAL INJURY

$4,000,000 Assets

$20,000,000 Claims Paid

52 Years Old

Physicians Casualty & Health Ass'ns.

Omaha 2, Nebraska

Therapeutic Skepticism

More time and more money spent on diagnostic procedures perhaps can shorten an illness and eliminate many expenses stemming from indiscriminate drugging. A clear understanding of the patient's illness and of the pharmacodynamics of the agent to be used is necessary for proper treatment. Recognition of uncomfortable side effects or actual dangers attending the use of a drug in comparison with the possible good that can be expected may alter the decision as to what agent is to be used. Too early and indiscriminate surgery, roentgen ray therapy, or drugging may cloud an already cloudy picture without benefiting either the clinical course of the patient or the understanding of the clinician. Our modern philosophy that doing something is a step in the right direction does not always hold true. In certain instances, "tincture of time," an effective agent when properly used, might be encouraged. More time spent in listening to the patient's story or examining him, and less time spent in writing prescriptions, giving shots, or writing orders on the chart probably will result in better medical practice. Finally, therapeutic nihilism should not be our aim in this modern era in which we are blessed with so many things with which to do good; rather, we should remain steadfastly against their misuses. By so doing, our patients will be safeguarded, our profession will avoid criticism, and we physicians will gain in stature in the eyes of those who follow us. *William H. Gordon, M.D., A Word in Favor of More Therapeutic Skepticism. Texas J. Med., Oct.* 1954.

‹ ›

A careful study of mass X-ray surveys (in Connecticut) covering more than 400,000 persons in a period of six years has shown that the highest percentage of cases of tuberculosis in men is found among service workers (such as barbers, cooks, waiters, janitors, etc.). In women, personal service workers, such as beauty operators, cooks, waitresses and practical nurses show the highest percentage incidence, but far below that of men in the same occupational classification. Paul S. Phelps, M.D., The John N. Wilson Memorial Lecture, April 30, 1954.



Establishing desired eating patterns

Obedrin®

and the 60-10-70 Basic Diet

With Obedrin and the 60-10-70 Basic Diet, the overweight patient receives specific, proved aids to control overeating. Loss of weight is accomplished more comfortably, while the patient develops new and better eating habits.*

OBEDRIN CONTAINS:

Methamphetamine for its anorexigenic and mood-lifting effects.

Pentobarbital as a corrective for any excitation that might occur.

Vitamins B_1 and B_2 plus niacin for diet supplementation.

Ascorbic acid to aid in the mobilization of tissue fluids.

Obedrin contains no artificial bulk, so the hazards of impaction are avoided. The 60-10-70 Basic Diet provides for a balanced food intake, with sufficient protein and roughage.

*Eisfelder, H. W.: Am. Pract. & Dig. Treat., 5:778 (Oct. 1954).

FORMULA:

Semoxydrine HCl (Methamphetamine HCl) 5 mg.; Pentobarbital 20 mg.; Ascorbic acid 100 mg.; Thiamine HCl 0.5 mg.; Riboflavin 1 mg.; Niacin 5 mg.

Write for 60-10-70 Diet Pads, Weight Charts, and samples of Obedrin.

The S. E. MASSENGILL COMPANY

Bristol, Tennessee

for CHILDREN with EDUCATIONAL and ADJUSTMENT PROBLEMS

. . . a private resident school for children of average or superior intelligence whose psychological difficulties impair their learning abilities and school progress.

. . . enrolling children from seven to fourteen years of age. Coeducational. Small classes. Remedial reading. Brochure on request.

. . . provides a program of education with psychotherapy.

. . . out-patient psychiatric evaluation and consultation for children.

ANN ARBOR SCHOOL

A. H. Kambly M.D., Director

411 First National Building Ann Arbor, Mich.

Another Lederle "First"!

MUMPS VACCINE

A practical immunizing antigen for prevention of mumps in children or adults where indicated.
Immunizes for about one year.
Packages: 2 cc. vial (1 immunization),
10 cc. vial (5 immunizations).

LEDERLE LABORATORIES DIVISION
AMERICAN Cyanamid COMPANY
PEARL RIVER, NEW YORK

Lederle

The hurdle of the specialty board

Over the past 50 years in medical America, we have been building walls at an alarming rate. The rate has accelerated since the war. Some of the walls are hurdles; for example, the specialty boards. These hurdles are erected to help maintain high standards of training for practicing specialists. As such they serve man's original purpose for walls—protection. When boards are introduced as criteria for a university faculty, however, they become standards of intellectual conformity. The job of the university is not only communication but the search for knowledge. The paths that lead there cannot be prescribed by a board.

A century ago, Claude Bernard warned experimental medicine against exaggerating the importance of erudition. More recently, Alan Gregg, in speaking to the dignified Assembly of the American College of Physicians, referred to the specialty board examinations in words to this effect: You are not finding out what the young men can do. You are not finding out what they know. You are merely finding out whether or not they know the same things you know. *Stewart Wolf, On Building Walls. Clin. Res. Proc. Sept. 1954.*

‹ ›

Thyroid nodules

Concern about the carcinogenic effect of radio-iodine has varied greatly in the minds of different investigators. Final conclusions regarding this apprehension can be resolved only after the substance has been given to a large number of patients over a long period. However, the absence of any reports of carcinoma developing in the thyroids of patients previously treated with radio-iodine is comforting and reassuring to some degree. Carcinoma has been found in nodules in the thyroids of patients previously treated with radio-iodine but only in nodules that had been present prior to the treatment. This fact is not a condemnation of radio-iodine but is rather a condemnation of treatment by nodules, for the presence of carcinoma in nodules in the thyroid gland cannot be determined with accuracy by clinical examination alone. *Samuel F. Haines, M. D., Treatment Of Exophthalmic Goiter. New York J. Med. Aug. 1, 1954.*



If the symptom-complex seems to indicate that the patient is "caffein-sensitive," he need not give up coffee. He need only give up drinking caffein. As you know, Sanka Coffee is 97% caffein-free.

P. S. Doctor, you ought to try Sanka Coffee yourself. It is wonderful coffee with a fine aroma and flavor.



SANKA COFFEE

DELICIOUS IN EITHER INSTANT OR REGULAR FORM

Products of General Foods

North Shore Health Resort

on the shores of Lake Michigan
WINNETKA, ILLINOIS
NERVOUS and MENTAL DISORDERS
ALCOHOLISM and DRUG ADDICTION
Modern Methods of Treatment
MODERATE RATES

Established 1901 — *Fully Approved by the*
Licensed by State of Illinois — *American College of Surgeons*

SAMUEL LIEBMAN, M.S., M.D.
Medical Director

225 Sheridan Road — Winnetka 6-0211

Expenditures and profits

Management is well aware that a decrease in expenditures is not necessarily synonymous with an increase in profits. Most of you can cite instances where a relatively petty saving at one time has necessitated relatively large and unavoidable expenditures at a later time. Similarly, increased or new expenditures are often considered the shortest way to previously unrealized profits. The concept is an infectious one which, I am sure, returns annually under many guises to plague budget directors. Many such propositions are approved and subsequently justify the faith placed in them. Probably more fall short of expectations. I fear that medical services usually are "sold" to management on such a basis. The argument is familiar to all of you. Spend a thousand, 10 thousand, or a million dollars per year on employee health services and we, the doctors, will provide a Utopia in which the chronically ill employee is replaced by an exuberantly healthy, happy, and productive worker. Somehow or other the millenium has not arrived in spite of the provision of various amounts and qualities of medical service to employees for a number of years. *Leo Wade, M. D., The Cost Of Medical Service. Medical Bull. March 1954.*

‹ ›

Reserpine

The actual site of action of reserpine is not definitely known. There is much evidence to suggest that it acts on the central nervous system, probably within the hypothalamus in particular. There has been no good evidence of any vasodilator activity of reserpine. There is no ganglionic blocking action. There is no peripheral sympatholytic action, and reserpine enhances the pressor effects of epinephrine and nor-epinephrine rather than inhibiting them. The hypotensive action of this substance is not altered by cutting the vagi and depressor nerves, and is not inhibited by atropine. Reserpine does not enhance the blood pressure lowering resulting from the intravenous administration of acetyl-choline to animals. This drug antagonizes pressor responses from central

FAIRVIEW
Sanitarium

DEVOTED TO THE ACTIVE TREATMENT OF

MENTAL and NERVOUS DISORDERS

Specializing in Psycho-Therapy, and Physiological therapies including:

- **Electro-Shock**
- **Electro-Narcosis**
- **Insulin Shock**
- **Carbon Dioxide Therapy**

Out Patient Shock Therapy Available

ALCOHOLISM Treated by Comprehensive Medical-Psychiatric Methods.

2828 S. PRAIRIE AVENUE, CHICAGO 16 J. DENNIS FREUND, M. D., Medical Director

Phone Victory 2-1650 — **Registered by the American Medical Assn.**

The NORBURY SANATORIUM

JACKSONVILLE, ILLINOIS — INCORPORATED and LICENSED

For the Treatment of Nervous and Mental Disorders

FRANK GARM NORBURY, M.D., Medical Director
HENRY A. DOLLEAR, M.D., Superintendent
FRANK B. NORBURY, M.D., Associate Physician

Address Communications — THE NORBURY SANATORIUM, Jacksonville, Illinois

vagal stimulation and carotid occlusion, but fails to inhibit the pressor response resulting from increased intracranial pressure (which acts through asphyxial stimulation of the vasomotor center). Whether the actual method of action is due to a blocking of the synaptic transmission through the central part of the autonomic nervous system between afferent and efferent neurons, or to a diminution of sensitivity of central sympathetic portions is not known. But it does appear that the primary site of action of reserpine is in the hypothalmus. *Story of Reserpine. J. Indiana M.A., Aug.* 1954.

‹ ›

Sympathectomy in frostbite

There has been a reawakening of interest in the study of frostbite and related cold injuries because of the large number of these casualties sustained during the recent Korean conflict. Lempke and Shumacker and Shumacker and his associates have carried out a series of controlled experimental investigations, which reveal that immediate rapid thawing is the most effective single therapeutic measure in preventing subsequent gangrene. Intensive anticoagulant therapy also is of benefit. The place of sympathectomy, however, has not been as definitely established. Arena et al., in animal experiments, conclude that early release of vasospasm by administration of tetraethylammonium chloride during the acute stage of frostbite causes increased edema and a transient wet type of gangrene to replace the dry gangrene to replace the dry gangrene seen in control animals. However, in the intermediate and late treatment of frostbite, according to Shumacker and Isaacson and Harrell, the indication for sympathectomy is certain. ACTH apparently has no effect. *Charles V. Menendez M. D. and Robert R. Linton, M. D., Periphral Vascular Diseases. New England J. Med. Sept. 2, 1954.*

‹ ›

If a little knowledge is dangerous, where is the man who has so much as to be out of danger? *Thomas H. Huxley.*

in whooping cough

ELIXIR BROMAURATE

IS A UNIQUE REMEDY OF UNIQUE MERIT

Cuts short the period of illness and relieves the distressing spasmodic cough. Also valuable in Bronchitis and Bronchial Asthma.

In four-ounce original bottles. A teaspoonful every 3 to 4 hours.

Prescribed by Thousands of Doctors

GOLD PHARMACAL CO. — NEW YORK CITY

THE
MEDICAL PROTECTIVE
COMPANY
FORT WAYNE, INDIANA

the doctor's most secure source of security

PROFESSIONAL PROTECTION
EXCLUSIVELY
SINCE 1899

CHICAGO Office:
T. J. Hoehn, E. M. Breier and
W. R. Clouston, Representatives,
1142-44 Marshall Field Annex Building,
Telephone State 2-0990

SPRINGFIELD Office:
F. A. Seeman, Representative,
Telephone Springfield 4-2251

Nonoccupational illness

Our costs for accidental injuries and occupational diseases are less than one-third the sick leave costs for nonoccupational illness and injury. Nevertheless, the nature and location of our oil refinery operations still make it imperative, in the interests of our workmen, that emergency medical facilities be available at the plant. The workman who is injured in an oil refinery expects, and rightly so, to receive the finest emergency medical care as soon as possible, and he looks to the company to bring this to him. His family is aware of some of the inherent hazards of his work and they too expect the company to have emergency care available. In General Petroleum, this care is given with the understanding that the employee will be sent to the nearest approved hospital for further treatment and also that we will make full use of the best specialists and consultants in the community, depending on the nature and extent of the disability. *E. P. Luongo, M.D., Plant Preventive Medicine Pays. Indust. Med., Jan. 1955.*

DOCTOR! you will approve the
3C's
Comfort, Cleanliness,
Convenience



at Bee Dozier's 3 Sanitariums for
Aged, Chronic, Senile, Convalescent
Patients.

Hickory Hill,
Maple Hill, *Palatine*

Charming, healthful rural locations conveniently situated, 24 hour care by trained nurses and orderlies, tempting food and supervised diets all contribute to your patient's well-being or recovery. 18 years of experience.

ONE rate covers EVERYTHING. There are NO extras.

Bee Dozier invites your inspection. Write Box 288, Lake Zurich, Ill., or Phone 4661

Prominent ears

Prominent ears may be unilateral or bilateral. Sometimes the abnormality may be more apparent than real. Very often, excessively large auricle or flattening of the auricle tends to give the appearance of a protruding or an outstanding ear. In our opinion, a true prominent ear cannot be permanently corrected by any such procedures as taping, bandaging the ears, ear muffs, or using retentive caps. Even in infancy, these methods are hopeless since the elastic recoil of the cartilage invariably will produce recurrence of the existing deformity. It also is true that operation which simply removes a section of skin and attaches the skin or the auricular cartilage to the post-auricular fascia does not correct the true prominent ears. This operative procedure only reduces the post-auricular sulcus and draws the scalp toward the back of the ear. The ear will still remain projecting, as previous to the operation. *Bert S. Jeremiah, M.D., Treatment of Prominent Ears. Rhode Island M. J., Oct. 1954.*



YOUTH IS THE TIME FOR YUVRAL*

VITAMINS AND MINERALS CAPSULES LEDERLE

For the big and important age group between pediatrics and geriatrics, Lederle offers YUVRAL Capsules, a new diet supplement. A highly potent formula including 11 vitamins, 13 minerals, and Purified Intrinsic Factor Concentrate—all in a dry-filled, soft-gelatin capsule with no unpleasant aftertaste.

Among adolescents and young adults, there are many "nutritionally starved" persons: those with strong dislikes for certain foods, those who won't drink milk, young women on self-prescribed diets. Just one YUVRAL Capsule daily assures them of an adequate supply of essential vitamins and minerals.

Each capsule contains:	
Vitamin A	5000 U.S.P. Units
Vitamin D	500 U.S.P. Units
Vitamin B_{12}	1 mcgm.
Thiamine Mononitrate (B_1)	3 mg.
Riboflavin (B_2)	3 mg.
Niacinamide	20 mg.
Folic Acid	0.2 mg.
Pyridoxine HCl (B_6)	0.5 mg.
Ca Pantothenate	1 mg.
Ascorbic Acid (C)	50 mg.
Vitamin E (as tocopheryl acetates)	5 I. U.
Iron (as $FeSO_4$)	15 mg.
Iodine (as KI)	0.15 mg.
Boron (as $Na_2B_4O_7.10H_2O$)	0.1 mg.
Copper (as CuO)	1 mg.
Fluorine (as CaF_2)	0.1 mg.
Purified Intrinsic Factor Concentrate	0.5 mg.
Magnesium (as MgO)	1 mg.
Manganese (as MnO_2)	1 mg.
Potassium (as K_2SO_4)	5 mg.
Zinc (as ZnO)	0.5 mg.
Calcium (as $CaHPO_4$)	69 mg.
Phosphorus (as $CaHPO_4$)	53.8 mg.
Dibasic Calcium Phosphate	236 mg.
Molybdenum (as $Na_2MoO_4.2H_2O$)	0.2 mg.

*REG. U.S. PAT OFF.

LEDERLE LABORATORIES DIVISION
AMERICAN Cyanamid COMPANY Pearl River, New York

Lederle

BELLEVUE PLACE

For

NERVOUS and MENTAL DISEASES

★

Edward Ross, M.D., Medical Director
BATAVIA ILLINOIS
PHONE BATAVIA 1520



LINCOLNVIEW

Hospital and Sanitarium
Springfield, Illinois
8th & Capitol

Albert P. Ludin, M. D., Medical Director

MENTAL-ALCOHOLIC-ADDICTED

Rapid Intensive Treatment

Registered A.M.A. Licensed State of Illinois

Phone 2-3303

Classified Ads

WANTED: Internist-Board Eligible, 29, avail. July 1955, family, group 4, desires ass'n with other internist or group. Prefers northern half of state, town 35,000 or more. Box 222, Ill. Med. Jl. 185 N. Wabash Ave., Chicago 1. 3/55

FOR RENT: Modern office, medical building, located in the heart of Albany Park, northeast corner Lawrence and S. Louis Avenues, shown by appointment EAstgate 7-8000.

WANTED: Cardiologist wishes to interpret electro-cardiograms for private physicians, indust, surgeons, group clinics, etc., in his office. Reports by return mail. Box 223, Ill. Med. Jl. 185 N. Wabash Ave. Chicago 1, Ill.

MEDICAL SPACE FOR RENT—South Suburb Chicago, 27,600 people, ground floor in Medical Bldg. with pharm. 2 hosp. nearby. Urgently need Gen. Pract. and Spec. Easy to purchase new housing and rental housing avail. Write or call Mr. Hawkins, AMERICAN COMMUNITY BUILDERS, INC., Park Forest, Illinois.

Appendicitis

There are three kinds of appendicitis: ruptured, with peritonitis; gangrenous; and unwarranted. *Letters to the Editor. J. Indiana M.A., Aug.* 1954.

‹ ›

Although modern chemotherapy of tuberculosis has contributed much in combating this disease, it is well to be reminded that the final conquest of tuberculosis is not yet in sight. Furthermore, there exist valid doubts whether the disease can ever be banished by the use of specific chemotherapeutic substances alone, even by drugs far more potent than any presently forseeable. William H. Feldman, M.D., Am. Rev. Tuberc., June, 1954.

De-aging

The average man of 50 or 60 is commonly from five to ten years "older" than he need be. As a man ages, his body becomes a documentary record of his past years. "The old man is a walking hospital." He shows accumulated damage, defects, tissue poisoning, stagnation, and starvation with half-cured illnesses and infections. These are the results, not of time but of the hazards that occur from accident, illness, strain, ignorance, or neglect in the passage of time. Our enemy is not age; it is damage, largely avoidable, largely correctable. (Ancel Keys makes an arresting statement to the effect that the American man of 50 has an expectation of dying before 60, 17 per cent greater than the English, 24 per cent greater than the Italian, and 55 per cent greater than the Swede of corresponding age.)

At any age — 40, 60, or 80 — there are accumulated burdens, defects, and deteriorations which in large part can be discovered and identified by thorough examination. The evils disclosed by examination may often be partly or wholly removed or neutralized. At the same time, unutilized sources of vitality and power may be disclosed and developed to a great advantage. *C. Ward Crampton, M.D., Medical Services in Aging and De-aging. New York J. Med., Oct. 15, 1954.*

THE KEELEY INSTITUTE
DWIGHT, ILLINOIS

Treating alcoholism and other problems of addiction.
REGISTERED BY THE AMERICAN MEDICAL ASSOCIATION—
MEMBER AMERICAN HOSPITAL ASSOCIATION.

Table of Contents

APRIL, 1955
Vol. 107, No. 4

YOUR ANNUAL MEETING—CHICAGO—MAY 17, 18, 19, 20

ORIGINAL ARTICLES

Combined Drug Therapy in Hypertension. Edward W. Cannady, M.D., F.A.C.P., East St. Louis 163

The Neuropsychiatrist In The General Hospital. Benjamin Boshes, M.D., Chicago 168

Overtreatment As A Cause of Disease, A Symposium. John S. Garvin, M.D., Adolph Rostenberg, Jr., M.D., Mitchell A. Spellberg, M.D., Harry K. Waddington, M.D. 171

Early Illinois Medicine. James H. Hutton, M.D., Chicago 174

The Illinois Department of Public Health. Roland R. Cross, M.D., Director 178

Treatment of Comedones in Acne Vulgaris with High Frequency Current. William A. Rosenberg, M.D., Chicago 181

EDITORIALS

Program for the annual meeting 187

B12 problems 184

The 1955 annual meeting 184

Continued growth of Illinois Medical Service 185

Statistics 185

Another Illinois physician honored by his home community 185

Dr. Warren W. Furey receives another honor 186

Dedication of the suburban Cook County Tuberculosis Hospital 186

Book Reviews 48A

MEDICAL ECONOMICS

Evolution of a Community Health Insurance Plan. William Requarth, M.D., Decatur 206

CORRESPONDENCE

Clinics for crippled children listed for May 208

Good use for old equipment 208

Allergists hold annual meeting 209

Annual meeting of American College of Chest Physicians 209

NEWS OF THE STATE 210

Editor
Harold M. Camp
Monmouth, Illinois

Associate Editor
Theodore Van Dellen
Chicago, Illinois

Business Manager and Managing Editor
Mr. L. E. Malley
185 N. Wabash Avenue
Chicago 1, Illinois

Business Office
185 N. Wabash Avenue
Chicago 1, Illinois

Editorial Office
Medical Arts Building
Monmouth, Illinois

Send original articles and membership correspondence to Harold M. Camp, Monmouth, Ill.

Send changes in the mailing list to Managing Editor, 185 N. Wabash Ave., Chicago 1, Ill.

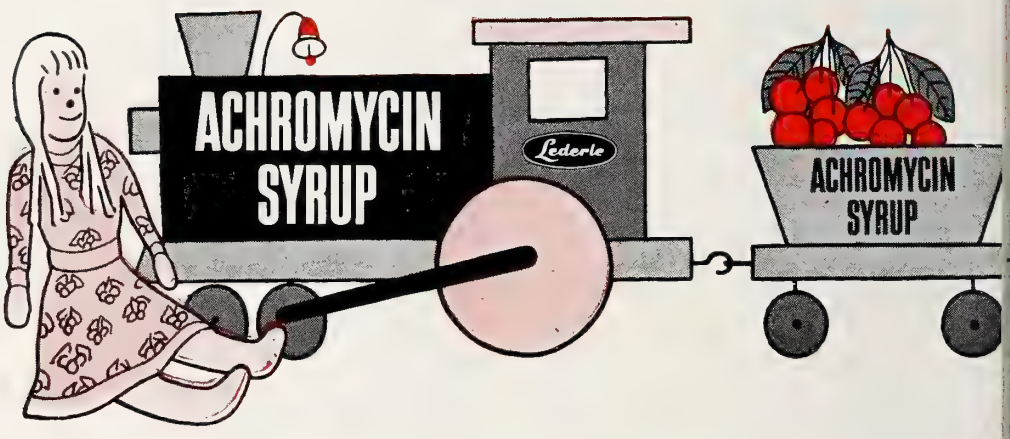
Subscription price of this JOURNAL to persons not members of the Illinois State Medical Society is $4.00 per year, in advance, postage prepaid, for the United States, Cuba, Puerto Rico, Philippine Islands, Hawaiian Islands and Mexico. $5.00 per year for all foreign countries included in the postal union. Canada, $4.50. Single current copies 50 cents. By mail, 60 cents.

Entered as Second-Class Matter November 12, 1952 at the Post Office, Mendota, Illinois, under the Act of March 8, 1879. Acceptance for mailing at special rate postage provided for in section 1102, Act of October 8, 1917, authorized July 15, 1918. Printed monthly by The Wayside Press, Mendota, Illinois. Office of Publication, 1501 W. Washington Road, Mendota, Illinois. POSTMASTER — Return underliverable copies under form 3579 to 1501 W. Washington Road, Mendota, Illinois.

PLEASANT CHERRY FLAVOR!

125 MG. PER 5 CC. TEASPOONFUL! NO REFRIGERATION!

AQUEOUS—NO OIL



ACHROMYCIN

TETRACYCLINE Le

OTHER FORMS OF ACHROMYCIN FOR PEDIATRIC USE:

Pediatric Drops (Cherry Flavor): 100 mg. per cc. (approx. 5 mg. per drop)

Oral Suspension (Cherry Flavor): 250 mg. per teaspoonful (5 cc.)

SPERSOIDS® Dispersible Powder (Chocolate Flavor): 50 mg. per rounded teaspoonful (3 Gm.)

relieve pain, headache, fever promptly and safely

APAMIDE®

(N-acetyl-p-aminophenol, *Ames*, 0.3 Gm.)

direct-acting analgesic-antipyretic...

no toxic by-products...

APAMIDE-VES

TRADEMARK

(Buffered N-acetyl-p-aminophenol, *Ames*, 0.3 Gm.)

effervescing analgesic-antipyretic...

speeds relief...assures fluid intake

APROMAL®

(acetylcarbromal and N-acetyl-p-aminophenol, *Ames*, 0.15 Gm. ea.)

sedative-analgesic-antipyretic...

calms patients and relieves pain

AMES

COMPANY, INC • ELKHART, INDIANA

Ames Company of Canada, Ltd., Toronto 59554

Everyone a specialist

I foresee the personal doctor of the future as the most important single unit in medical care. He will be the well trained internist, because the internist of today is not a specialist in the strict sense of the word. Like the family doctor of the past, the family physician of the future should serve as health adviser and health educator and as a leader in developing the health resources of the community. He will differ greatly from the family doctor of the past, however, in the resources at his command. In addition to his black bag, he carries with him the potentialities for ready access to topnotch consultants in the medical specialties, to hospitals with their resources, and to a wide range of preventive and rehabilitative services. Through him, the patient will be assured continuity of care, adequate interpretation of his health needs, and understanding of his problems as a person, without sacrificing the quality of care he receives. In good medical care there is no substitute for the personal doctor-patient relationship. *Chester S. Keefer, M.D., The Future of The Private Practice of Medicine. J. Kansas Med. S., Feb.* 1955.

‹ ›

The routine chest survey yields a certain amount of asymptomatic pathology. The yield depends on multiple factors, of which age, sex, occupation, and family history are perhaps the most significant. We expect that 5 per cent of all routine chest films taken on the so-called healthy population will yield some degree of intrathoracic abnormality and that at least 10 per cent of routine chest films taken on hospital admissions will show significant pathology. The routine chest film should be as much a part of a good physical examination as is a blood count or a urine analysis. *Ida Levine, M.D. & Henry Greenfield, M.D., New York J. of Med., Dec.,* 1954.

‹ ›

The young man who has not wept is a savage, and the old man who will not laugh is a fool.—*Santayana*



To build giant-size appetites, prescribe...

Redisol®

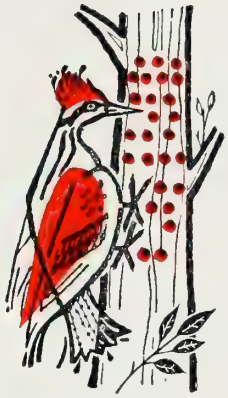
CRYSTALLINE VITAMIN B_{12}

MAJOR ADVANTAGES: Helps youngsters gain weight. Stimulates hemopoiesis. Cherry-flavored *Elixir* or soluble *Tablets* readily blend with milk, juices, infant formulas.

Supplied as REDISOL *Tablets:* 25,50, 100, 250 *mcg.; Elixir: 5 mcg.* per 5 cc.; *Injectable:* 30, 100, 1000 *mcg.* per cc.

SHARP & DOHME

Philadelphia 1, Pa.
DIVISION OF
MERCK & CO., INC.



Establishing desired eating patterns

Obedrin®

and the 60-10-70 Basic Diet

With Obedrin and the 60-10-70 Basic Diet, the overweight patient receives specific, proved aids to control overeating. Loss of weight is accomplished more comfortably, while the patient develops new and better eating habits.*

OBEDRIN CONTAINS:

Methamphetamine for its anorexigenic and mood-lifting effects.

Pentobarbital as a corrective for any excitation that might occur.

Vitamins B_1 and B_2 plus niacin for diet supplementation.

Ascorbic acid to aid in the mobilization of tissue fluids.

Obedrin contains no artificial bulk, so the hazards of impaction are avoided. The 60-10-70 Basic Diet provides for a balanced food intake, with sufficient protein and roughage.

*Eisfelder, H. W.: Am. Pract. & Dig. Treat., *5*:778 (Oct. 1954).

FORMULA:

Semoxydrine HCl (Methamphetamine HCl) 5 mg.; Pentobarbital 20 mg.; Ascorbic acid 100 mg.; Thiamine HCl 0.5 mg.; Riboflavin 1 mg.; Niacin 5 mg.

Write for 60-10-70 Diet Pads, Weight Charts, and samples of Obedrin.

The S. E. MASSENGILL COMPANY

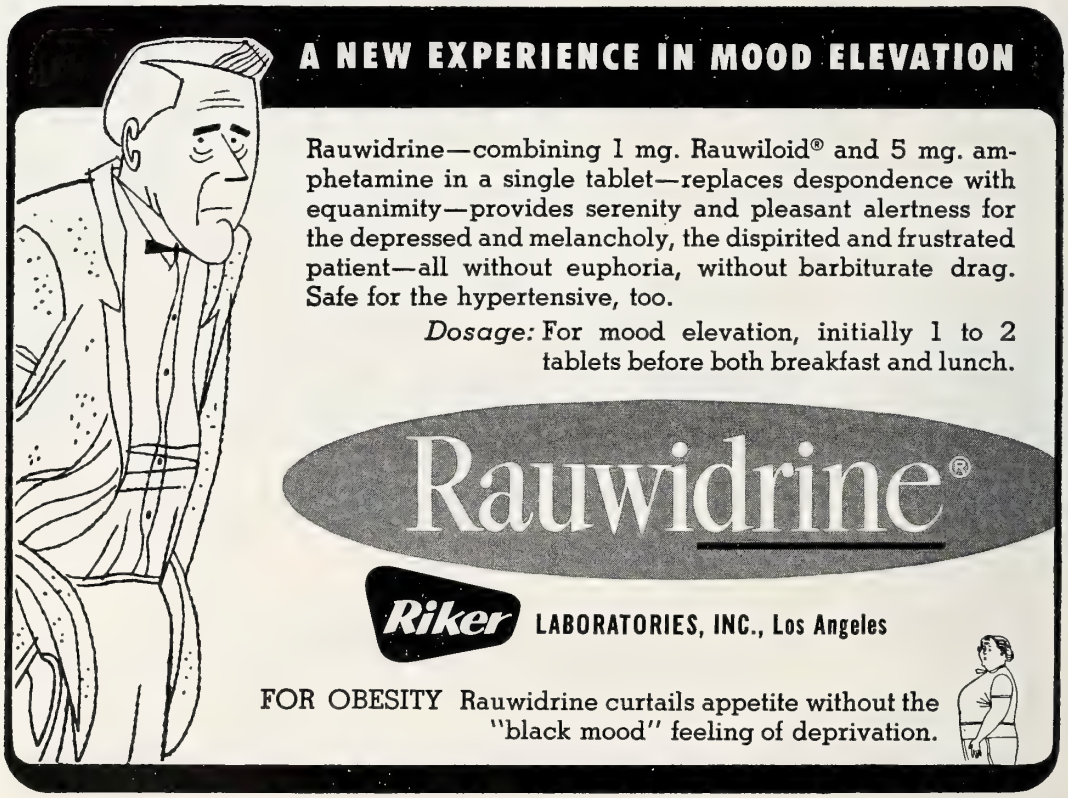
Bristol, Tennessee

CSF in brief

Nonbacterial regional lymphadenitis (cat scratch fever), usually a benign disease, has been reported from many areas of the world. Studies, as summarized by Debre and Job, have revealed the following data. Although the causative agent has not been isolated, the disease has been transmitted to human volunteers and monkeys. The pathology of the involved lymph nodes follows a definite but not pathognomonic pattern. In about 50 per cent of the reported cases, a history of contact with cats, including cat scratches, has been elicited. There is a characteristic, seldom fatal, clinical course; regional lymphadenitis follows a primary lesion at or near the site of trauma. Positive complement-fixation tests for lymphogranuloma venereum have been mentioned in variable percentages by different investigators. Broad-spectrum antibiotics have been described as hastening recovery in some cases. Lastly, there is a "specific" intradermal diagnostic test in which a tuberculin-type hypersensitivity reaction is evoked by the inoculation into a patient of heated pus aspirated from suppurative lymph nodes of persons suffering from the disease. *Joseph J. McGovern, M.D., et al., Nonbacterial Regional Lymphadenitis (Cat Scratch Fever). New England J. Med., Feb.* 3, 1955.

‹ ›

We have arrived at the cold war stage of the struggle with tuberculosis, and it has many likenesses to the cold war in the international field. Both lack the spur of win-or-lose combat which arouses enthusiasm. Diplomats can't feel as heroic going to a conference where they will inch along by argument as when they march off with a regiment but, unheroic as they feel, they can't let it interfere with their alertness, tenacity, or industry. . . . . There is danger that, in the cold-war stage of the campaign against tuberculosis, we may lose the zest which our pioneers felt in grappling with death. *George J. Wherrett, M.D., Transactions NTA, May,* 1954.



The
ILLINOIS
Medical Journal



Official Journal of The Illinois State Medical Society

APRIL 1955
VOL. 107 NO. 4

Combined Drug Therapy in HYPERTENSION

Edward W. Cannady, M.D., F.A.C.P., East St. Louis

THE development of powerful antihypertensive drugs has introduced a new approach to the treatment of severe hypertension and its more serious counterpart malignant hypertension. Following the publication of numerous reports indicating the blood pressure reducing properties of several new drugs an attempt was made to determine the practical use of these drugs on a group of ambulatory office patients having moderate to severe benign hypertension. All were private patients and most had been observed for periods varying from a few months to 13 years under other forms of treatment including low sodium diets and numerous drugs (phenobarbital, nitrates, xanthine preparations and thiocyanate).

During the initial period each of the antihypertensive drugs investigated was used alone and later in combination. Since the purpose of the investigation was to determine the practical effectiveness of the drugs on typical office patients the results will not be reported on a statistical basis but as observations on the difficulties encountered and the effects obtained. Only those drugs which could be taken by mouth were used. Drugs used were hydralazine (apresoline), rauwolfia, protoveratrine and hexamethonium. Results were considered satisfactory if the patient tolerated the drugs without disagreeable side effects and the blood pressure was maintained below 160mm. systolic and 100mm. diastolic.

Since it is recognized that some of these drugs may be hazardous to use we are confronted with the question, What can one accomplish by lowering blood pressure, which patients should be treated with the new drugs and what drugs should be used in the individual case?

Three organs or systems of the body are particularly vulnerable to the effects of hypertension; namely the heart and blood vessels, the brain and the kidneys. Therapeutic goals in hypertension should be prevention or postponement of the effects of hypertensive strain resulting in cardiac decompensation, cerebrovascular accidents, renal failure and the progression of benign hypertension into the severe and malignant forms of the disease. Expensive and hazardous drug therapy can be justified

Instructor in Clinical Medicine, Washington University School of Medicine, St. Louis, Missouri.

Presented before the Section on Cardiovascular Disease, Illinois State Medical Society, 114th annual meeting, Chicago, May 18, 1954.

only if the pace or expected course of the disease represents a threat either to the patient's life or to his continued well being. The relatively benign course of many cases with mild to moderate hypertension does not justify intensive therapy with the more hazardous drugs. This is especially true of many hypertensive middle aged women and hypertension in the aged. However, much can often be gained by therapy in the severe and malignant forms of hypertension where the risk of the disease outweighs the possible dangers from the use of the more effective and hazardous antihypertensive drugs.

A thorough investigation for classification of the patient was done before determining the therapeutic course of action. Such study consisted of a complete history and physical examination including the ocular fundi, urinalysis, renal function studies, electrocardiogram, chest x-ray or fluoroscopy and screening for pheochromocytoma where indicated. Although 95 percent of patients with hypertension fall into the essential group it is important to exclude those patients having hypertension from other causes such as coarctation of the aorta, structural renal disease and pheochromocytoma.

Ambulatory patients with moderate to severe essential hypertension were treated with hydralazine, rauwolfia, or protoveratrine. Each drug was used alone until it was determined that a satisfactory blood pressure response had not occurred. The drugs were then used in combination. When combinations of the drugs failed to produce a satisfactory response the patient was hospitalized and hexamethonium was added to the regime. A few patients with very severe benign hypertension and all with malignant hypertension were hospitalized immediately and hexamethonium was administered before any of the other drugs were used.

Rauwolfia is an old drug, used in India for many years, especially as a sedative but its use in the treatment of hypertension is comparatively recent. Rauwolfia has a moderate hypotensive action. The fall in pressure is gradual, usually taking place in four to seven days but the full effect may not appear for six weeks. Nasal stuffiness and mild gastrointestinal complaints were the only uncomfortable side effects encountered in our patients. Rauwolfia is often a satisfactory drug used alone in patients with very moderate, labile hypertension accompanied by tachycardia. The heart rate is usually slowed. Since the drug is relatively safe frequent examinations are not necessary and most patients were seen at two week intervals or longer. Rauwolfia used alone was not effective in producing a satisfactory fall in blood pressure in patients having more than a very moderate hypertension. Two preparations were used, Raudixin (crude powered root) and Serpasil (alkaloidal extract). The usual dose of Raudixin varied from 100mm. to 300mg. daily in two to three divided doses. One milligram or less of Serpasil was given daily usually in one dose at bedtime.

Protoveratrine, the pure alkaloid of veratrum, was not effective used alone in producing a satisfactory fall in blood pressure. The effective dosage range is limited by the frequent undesirable appearance of nausea and vomiting.

Hydralazine (Apresoline) is an adrenergic blocking agent. Hydralazine used alone was not successful in maintaining a satisfactory blood pressure level. The usual dose at the onset of treatment was 25mg. every four to six hours. Each dose was increased every few days by the addition of 25 mg until the average patient received 150mg. four or five times daily. Undesirable side effects often caused considerable difficulty and in some cases prevented continuing the drug. Most frequent reactions included headache, tachycardia with palpitation, dizziness, nasal stuffiness, weakness and generalized aching. One patient developed jaundice following forty-eight hour administration of hydralazine, This occurred on two occasions and disappeared promptly after discontinuing the hydralazine. Subsequent studies revealed no other cause for the icterus. Attempts to initiate treatment with 10mg. doses every four hours and increasing each dose 10mg. every few days did not decrease the frequency of undesirable side effects, reactions appearing when the dose reached therapeutic levels. When drugs were used in combination undesirable side effects of hydralazine seemed less frequent. None of our patients developed the more serious reactions of drug fever, gastrointestinal hemorrhage, blood dyscrasias or manifestations of collagen diseases especially arthralgia[1].

Hexamethonium is probably the most controversial drug used in the treatment of hypertension. It is a ganglionic blocking agent achieving sympathetic nervous inhibition often at the expense of parasympathetic nervous inhibition. Postural hypotension usually occurs and is often troublesome. Faintness and even fainting in the erect position are common. Unless blood pressure readings are made in the erect position, the maximum hypotensive response will not be determined. Constipation due to depressed gastrointestinal motility is frequent and must be controlled by adequate catharsis to prevent excessive accumulation of the hexamethonium. Dryness of the mouth and lack of visual accommodation are seen. Hypotonicity of the bladder is common but usually transient. We did not encounter the more serious complications of dyspnoea in the upright position, fatal parotitis and adynamic ileus. The hazards of hexamethonium therapy are so great that treatment should always be instituted in a hospital and complete instructions must be given to the nursing staff regarding the care and observation of the patient. Marked fluctuations in blood pressure were often observed in the same patient from day to day on a constant dose. Hexamethonium was used only in the severe benign and malignant cases of hypertension and in those patients with moderate hypertension failing to respond to the other hypotensive drugs. The initial dose was 125mg. every four hours. Each dose was increased 125mg. daily until the average patient received 500mg. every four hours. A few patients received a larger dose and several required a smaller amount. The middle of the night dose was omitted before the patient was discharged from the hospital. Blood pressure determinations were made before each dose and the dose adjusted according to the pressure. The schedule of dosage advised by Schroeder[2] was followed. Although several patients with severe hypertension demonstrated a significant fall in blood pressure when hexamethonium chloride was used alone, none maintained normotensive levels over a satisfactory period.

We have had no experience with pentapyrrolidinium (M & B 2050) but according to Freis and his associates[3] this new ganglionic blocking agent has several advantages over hexamethonium including longer duration of action and a more uniform response from day to day on oral administration.

After observing unsatisfactory results with all of the antihypertensive drugs used alone an attempt was made to evaluate the response to several combinations of the various drugs.

A group of patients had been receiving hydralazine alone with unsatisfactory results. After rauwolfia became available this was used in addition to hydralazine. Lowering and maintaining a satisfactory level of blood pressure was much more successful with the combined use of hydralazine and rauwolfia than with either drug alone. Our most satisfactory results were obtained with combined hydralazine-rauwolfia treatment in patients having moderate hypertension. The following cases demonstrate the result frequently observed with hydralazine and rauwolfia.

Case 1. O.D., a 47 year old engineer, had known hypertension for five years. His complaints included precordial discomfort not definitely related to exertion. Physical examination revealed a blood pressure of 204mm. systolic and 130mm. diastolic, mild arteriosclerotic changes in the ocular fundi, moderate cardiac enlargement and frequent premature ventricular contractions. Intravenous pyelograms revealed the kidneys to be of normal size, shape and position with normal appearance of the dye in each kidney. Intravenous phenolsulfonphthalein excretion was 35 percent in 15 minutes. The electrocardiogram showed evidence of left ventricular hypertrophy. Other laboratory procedures including urinalysis, non-protein-nitrogen, blood counts, fasting blood sugar, blood Kahn and basal metabolic rate were within normal limits. Hydralazine was started and the amount gradually increased to 150 mg. four times daily. Headaches resulting from hydralazine were controlled with benadryl. During the period when hydralazine was used alone the lowest blood pressure was 170mm. systolic and 120mm. diastolic. After rauwolfia (Raudixin) was added in doses of 100mg. every 12 hours the blood pressure varied between 146mm. systolic and 92mm. diastolic and 150mm. systolic and 90mm. diastolic. The precordial discomfort and premature ventricular contractions disappeared.

Case 2. H. K., a 36 year old high school principal, was seen in 1941 with a blood pressure of 160mm. systolic and 110mm. diastolic. Symptoms included dizziness, fatigue, leg pain, frontal headaches and fear of a cerebrovascular accident because of a family history of many such episodes. Physical examination was negative except for some tortuosity of the vessels in the ocular fundi. Renal function was within normal limits. Potassium thiocyanate was administered after the blood pressure had increased to 180mm. systolic and 120mm. diastolic. Thiocyanate was continued from 1944 to May, 1953. Blood thiocyanate determinations were made at

regular intervals. A satisfactory response occurred and persisted until 1953 when the blood pressure increased to 200mm. systolic and 130mm. diastolic. Thiocyanate was discontinued and hydralazine was given in gradually increasing doses to 150 mg. four times a day. Blood pressure eventually varied from 170mm. systolic and 106mm. diastolic to 160mm. systolic and 110mm. diastolic. Rauwolfia was added to the hydralazine therapy in doses of 100 mg. daily (Raudixin) with a blood pressure response varying between 140mm. systolic and 100mm. diastolic and 130mm. systolic and 80mm. diastolic. He had no complaints, stating that he felt better than he had at any time in several years.

Patients failing to respond to hydralazine-rauwolfia therapy were hospitalized and often demonstrated a more satisfactory response when hexamethonium was administered as an additional drug.

The results of the combined use of protoveratrine and rauwolfia were not satisfactory in most patients. Encouraging results occurred in the following case but the regime included weight reduction in addition to therapy.

Case 3. C.G., a 47 year old foreman, had known hypertension for 10 years when he was first seen in 1947. His complaints were dyspnoea, palpitation, slight ankle edema, headaches, nocturia and aching of both feet. Physical examination included a weight of 242 pounds, blood pressure of 175mm. systolic and 110mm. diastolic, a moderately enlarged heart, an increased diameter of the ascending aorta, bilateral varicose veins and moderate arteriosclerotic changes in the ocular fundi. A weight reduction program resulted in a loss of 45 pounds in 14 months and blood pressure reduction to 148mm. systolic and 90mm. diastolic. The patient was not seen from June 5, 1948 to January 30, 1954. During this period his weight increased to 243 pounds and his blood pressure to 220mm. systolic and 124mm. diastolic. The previous symptoms had recurred. Physical findings were similar to those mentioned above. The electrocardiogram showed evidence of posterior myocardial damage. Intravenous phenolsulfonphthalein excretion was 15 percent in 15 minutes. The urine contained an occasional hyaline cast. Blood counts, Kahn, blood sugar, nonprotein nitrogen and bromsulfathalein excretion were within normal limits. Weight reduction was again advised. Rauwolfia was given in doses of 100 mg. every 12 hours (Raudixin). After six weeks he had lost 18 pounds and the blood pressure was 170mm. systolic and 100mm. diastolic. Protoveratrine was added (0.5mg. three times daily). Weight loss continued and after an additional six weeks he weighed 213 pounds with a blood pressure of 130mm. systolic and 80mm. diastolic. Weight reduction alone was probably a considerable factor in the improvement in the blood pressure since good results had occurred previously without drug therapy.

We have not used protoveratrine combined with hydralazine or hexamethonium.

Although the purpose of this investigation was to determine the practical use and effectiveness of the antihypertensive drugs in regulating typical office patients on an ambulatory basis those patients having very severe benign hypertension and malignant hypertension were hospitalized immediately and treated with Schroeder's Hyphex treatment[2]. This consists of a gradual increase in the dose of hexamethonium until the average patient receives approximately three grams daily in six divided doses. Hydralazine is then started in gradually increasing doses, the average maximum dose being 100mg. every four hours. A few patients require larger doses of both hexamethonium and hydralazine. Hexamethonium and hydralazine should never be started simultaneously. Disastrous results have been reported when the treatment was discontinued in patients having malignant hypertension[2]. Hyphex treatment should never be used unless the patient is hospitalized and the schedule of treatment and precautions advised by Schroeder rigidly followed. The treatment is hazardous and should be restricted to very severe benign and malignant types of patients. In such cases the combined use of the two drugs has proven effective and the benefits obtained outweighed the risks involved.

The following case illustrates the response to Hyphex treatment in a young patient with severe benign hypertension.

Case 4. J.S., an 18 year old white male had known hypertension for two years. He had been rejected for employment and by the military services. Complaints included dyspnoea on exertion, profuse perspiration, headaches, constipation and weakness. There was no definite history of acute nephritis. Physical examination revealed a blood pressure of 210mm. to 250mm. systolic and 150mm. diastolic, narrowing of the arterioles in the ocular fundi without hemorrhages or exudate and a moderately enlarged heart. The electrocardiogram showed slightly inverted T waves in AvF and inverted T waves in V-4 and V-5. T was up in V-2 and V-3 and low up to flat in V-6, unusually tall R waves were present in V-5 and V-6. There were five to six red blood cells per high powered field in the centrifuged urine specimen. He entered Christian Welfare Hospital in East St. Louis, for further investigation and treatment. Intravenous pyelograms and chest x-rays were negative. Blood sugar was 113mg. percent, nonprotein nitrogen varied between 48mg. percent and 31mg. percent, blood cholesterol, 111mg. percent, intravenous phenolsulfonphthalein excretion 40 percent in 15 minutes and Kahn negative. Examinations for pheo-

chromocytoma were negative. An insignificant fall in blood pressure followed large doses of sodium amytal. Hyphex treatment was instituted. After hexamethonium was gradually increased to 500 mg. every four hours hydralazine was added and the dose gradually increased to 100 mg. every four hours. A very satisfactory fall in blood pressure occurred and has been maintained varying from 146mm. systolic and 96mm. diastolic to 136mm. systolic and 86mm. diastolic. However, wide fluctuations in blood pressure occurred before the dose of hexamethonium was finally stabilized. Headaches and weakness were troublesome during the first few days of hydralazine therapy. Eventually the headaches were controlled with the addition of benadryl.

The following case illustrates the clinical response of a case of malignant hypertension to rauwolfia-hydralazine-hexamethonium therapy. The usual hyphex schedule was varied, rauwolfia and hydralazine being administered before hexamethonium.

Case 5. M.M., a 42 year old woman was examined in 1942 because of numbness and blanching of the fingers in cold weather, fatigue, hot flashes and headaches. Physical examination was negative except for moderate obesity and blood pressure of 160mm. systolic and 110mm. diastolic. The symptoms were attributed to early Raynaud's disease and menopause. Blood pressure in 1945 was 180mm. systolic and 110mm. diastolic, in 1948 200mm. systolic and 110mm. diastolic and in 1950 200mm. systolic and 120mm. diastolic. Treatment during this period consisted of weight reduction and barbiturates. The patient was not seen from November, 1951 to November, 1953, when she returned complaining of precordial discomfort, nervousness, insomnia and weight loss. Her blood pressure was 230mm. systolic and 160mm. diastolic. Ocular fundi showed papilloedema, hemorrhages and exudate. The heart was moderately enlarged and the rate 116 per minute. Laboratory examinations included a four plus albuminuria, nonprotein nitrogen 43 mg. percent, fasting blood sugar 133 mg. percent, blood sugar two hours after breakfast 93 mg. percent and a negative Kahn. Electrocardiogram revealed left ventricular hypertrophy with strain pattern. Patient was admitted to St. Mary's Hospital, East St. Louis for treatment of malignant hypertension. Rauwolfia (Raudixin) was given in doses of 200mg. daily. Hydralazine was administered and the dose gradually increased to 100 mg. every four hours. Before hexamethonium was given the blood pressure was 195mm. systolic and 110mm. diastolic. After hexamethonium had been increased and maintained at 500 mg. every four hours the blood pressure fell to normotensive levels. Patient improved symptomatically and the papilloedema of the ocular fundi disappeared. During regulation with hexamethonium the usual difficulties were encountered including wide blood pressure fluctuations, fainting sensations in the erect position and weakness. No difficulty was encountered with hydralazine.

We have had no serious complications in the small group of patients receiving combined hexamethonium and hydralazine therapy. Schroeder[1] recently reported five deaths in negroes caused apparently by pulmonary complications identified as acute interstitial fibrosis of the lungs. We did not encounter this complication probably because none of our patients were negroes.

Our present plan of treating ambulatory office patients with moderate hypertension consists of administering rauwolfia for four to six weeks and if the blood pressure response is satisfactory no other drugs are used. Hydralazine is added in gradually increasing doses to those patients whose blood pressure continues to be elevated above a relatively safe level. The blood pressure of most patients with moderate hypertension responds to the rauwolfia — hydralazine combination. Since the effective dose of each drug often varies a single tablet containing both drugs is never used. Although normotensive levels are often not reached and maintained the blood pressure frequently is lowered to a level where there is much less danger of complications from hypertensive strain. Patients whose blood pressure fails to respond to rauwolfia and hydralazine are hospitalized and hexamethonium is added to the regime. However, the addition of hexamethonium increases the expense and hazards of therapy in addition to complicating the life of the patient with blood pressure determinations frequently during the day and night. The middle of the night doses of both hexamethonium and hydralazine are usually discontinued before the patient is discharged from the hospital. Patients with very severe benign hypertension and malignant hypertension are hospitalized immediately and treatment instituted with Schroeder's Hyphex regime.

BIBLIOGRAPHY

1. Dustan, H.P.; Taylor, R.D.; Corcoran, A.C.; and Page, I.H.: Syndrome Elicitated by Prolonged Administration of Large Doses of Hydralazine, Proc. Central Soc. Clin. Res. **26**:32, 1953. Morrow, J.D.; Schroeder, H.A., and Perry, H. M., Jr.: Studies on the Control of Hypertension by Hyphex: II Toxic Reactions and Side Effects, Circulation **8**:829, 1953. Perry, H. M., Jr. and Schroeder, H. A.: Syndrome Simulating Collagen Disease Caused by Hydralazine, J.A.M.A. **1954**: 670 (Feb. 20) 1954. N. Balfour Slonim: Arthralgia, Headache, Prostration, and Fever During Hydralazine Therapy, J.A.M.A. **154**: 1419 (April 24) 1954.
2. Schroeder, H. A., Hypertensive Diseases, Causes and Control, Lea and Febiger, 1953.
3. A Clinical Appraisal of Pentapyrrolidinium (M & B 2050) in Hypertensive Patients, Edward D. Freis, Edward A. Partenope, Lawrence S. Lilienfield and John C. Rose, Circulation, **9**: 540, 1954 (April).

The Neuropsychiatrist In The General Hospital

Benjamin Boshes, M.D., Chicago

THE role of the neuropsychiatrist has been evolving progressively since the nineteenth century when he was identified chiefly as a doctor in a remotely located mental hospital, then called an "insane asylum". There was also the neurologist, a learned, dignified man who awed everyone with his knowledge of the pathways and nuclei of the nervous system. He examined the patient, gave an erudite diagnosis, and left. Not least was the more recent psychoanalyst, usually of the Freudian philosophy. He was identified even by some doctors with discussions of sex, neurotic indolent women, characters in plays and caricatures in the New York magazine. Actually no one of these is more closely related to the present neuro-psychiatrist than a barber is to the modern surgeon. Yet there was a day when the latter two were linked.

Today the neuropsychiatrist is a doctor of medicine, graduated from a Class A Medical School. He has completed an interneship, and if certified, has had 5 additional years in neurology or psychiatry, or 7 years in both. Then he must pass his Board examination, a not inconsequential hurdle.

Despite the popular application of psychiatry to education, religion, literature, music, theater, etc., the roots are in medicine and the broadest usages are here. The brain is the organ of of the mind. The spinal cord and peripheral nerves carry messages to and from the center. Through these and through the network of the automatic nervous system, every part of the body, be it viscus, muscle or gland is supplied neurally. This is the system of communication which tells when different areas are affected. When the nervous system is directly involved by dysfunction or disease, all associated somatic structures record the reaction, each in its own way. Therfore there is no splitting of psyche and soma. They are one and function in an integrative manner. Emotional distress, often repressed, produces organic dysfunction, to wit: the colitis and ulcer patient. The cardiac cripple is irrascible, irritable because of his inability to get around, and does himself more harm in his fuming than if he were actually doing work.

The circle of symptoms is complete. One cannot practice only physical medicine on human beings. It is essential therefore that the apparent functional be separated from the organic, and that the general organic be dissected away from the neurologic organic, so that each may be evaluated and definitive treatment outlined. It is essential to recognize that certain functional symptoms are not "just neurotic". Such symptoms serve a function to the organism and are often the "decompressing mechanism" which prevents a major psychosis. For example, a successful lawyer of 62 had gone from doctor to doctor and from clinic to clinic across the country for a peptic ulcer syndrome. No one could demonstrate the ulcer by x-ray or gastroscopy. A discerning surgeon asked for a neuropsychiatric opinion and was told that this was a somatic expression which masked a dangerous involutional melancholia. Tactful explanation to the family only, not to the patient, resulted in both surgeon and neuropsychiatrist being dismissed from the case. Three days later the patient was a suicide and the autopsy revealed no ulcer. The symptom was a facade of a major phychosis.

Often the neuropsychiatrist is called upon to answer the question as to the meaning of a hypochondriacal preoccupation of the patient

From the Department of Neurology and Psychiatry, Northwestern University Medical School, Chicago, Illinois.

Presented before the General Assembly, 114th Annual Meeting, Illinois, at its Medical Society, May 20, 1954.

with his symptom. Shall he be told that there is no organic substantiation? Shall we take the symptom away and thereby risk precipitating a major break with potential self-destruction? Such questions give pause for serious reflection.

In many general hospitals one can really face the issue frontally because the institution possesses a well-equipped psychiatric unit. The symptoms may be released in a setting where suicide cannot occur, and what is more, where definitive care can be instituted. In the younger patient, psychotherapy can help the person understand the basic meaning of his distress so that he can face the emotional problems of the future with insight as to the organic response. Older, intransigeant patients, or those frankly psychotic can be treated with shock therapy. The new curarizing drugs permit elec troshock in the old, in cardiacs, and even in postoperatives and those with fractures. The incidence of good results is amazingly high.

Yet one cannot be of a unilateral discipline. The organic nervous system directly involved may produce bizarre symptoms. The woman who is having nightmares that her house is on fire and who beats up her husband in bed after night, turns out to have an olfactory ridge meningioma. The "dream" of burning wood is the localizing aura, and the "beating" is a grand mal convulsion, misinterpreted by the husband lying at her side. The overbearing, unpleasant executive becomes worse than ever, so that his wife asks the family doctor to hospitalize him for study. Neuropsychiatric examination reveals subdural hematomas over the frontal lobes. The organic lesion has released the restraints on his previously obnoxious personality pattern, an "organic release" which required surgery to save his life. But the typist whose hands draw up in spasm at work does not have a calcium deficiency, a hyperventilation or a scalenus anticus syndrome. She has a "conversion reaction" which has to do with experiences which started at age of 5 when the father beat up the mother, crippling her permanently, then left the family stranded. This girl has been working since age 15, and now at 43 faces increasing office responsibilities, the menopause and the downhill of life, with much anxiety. She is childless, her husband is in a State hospital. She has never known security; she needs a "neurotic" escape.

A surgeon asks the question, "Is this patient a good risk for operation? She has had 14 major procedures in the past". The record verifies his statement; yet one wonders why the polysurgery? At no place in the chart is there a description of pathology. However, there are listed hysterectomy, laminectomy, mastectomy, sympathectomy and partial gastrectomy. The patient is 48, has persistent costo-vertebral angle pain, relieved only by demerol or dolophine. What can the surgeon do, explore further? What can he cut out safely? She is down to a minimum of organs already. A careful psychiatric history from the family shows that even at age 6 this person was controlling the world around her through illness. She permitted shots, casts, surgery, but she effectively punished those about her. They worried about her and paid medical bills. She is a hostile, hateful person, classified as a character neurosis with sado-masochistic features. Every doctor has met them. Families need protection from them, but unwitting, kindly physicians, trying to be good fellows, are taken in. These patients pit one doctor against another, nurses against attendants, and when the pot of turmoil is brought to full boil, take off and sue doctors, hospital and nurses. They are bright and find a lawyer who "understands" them. To avoid the nuisance and time loss, the doctors, nurses and hospitals cancel their bills and the patient has won. She has had weeks of the most solicitous care, drugs (to which she is often addicted) and satisfaction. Now she is rested and looks around for a new set of victims, totally unaware of the unconscious motivation for her acts.

The neuropsychiatrist often faces a grave responsibility when asked to evaluate as simple a symptom as anxiety. One patient in the emergency room is very anxious. Large beads of sweat stand out on his forehead. He can only say "I'm worried, I can't think. I'm worried". The anxiety is all out of proportion to anything functional. Cardiac auscultation reveals very faint heart sounds. Minutes later he is dead of a heart tamponade as an infarcted area gives way, flooding the pericardial sac.

The girl with lupus erythematosis is also anxious, her pupils widely dilated. She can

only say I'm so edgy today". She looks as though she is about to have a convulsion and actually 30 minutes later goes into a status epilepticus. She has been on ACTH and has an encephalopathic reaction.

The dental student's wife, age 21, delivers twins. Two days later her blood pressure is 190/110 and the convulsions start. Three days hence these are under control, but now she hears voices. "Satan has entered her and she is the Devil". Suicide is her only out. However she is quite safe in the psychiatric unit where she is getting routine post-partum care and anti-epileptic medication while the toxic psychosis wears off. But we must isolate her from her mother and her husband, both members of a cult which dotes on sin and Satan and who persist in reading what they call "selected pages from the Bible".

The surgeon has operated a man for an acute belly and no pathology is found. Three days later the patient is depressed, and to quote the surgeon "won't even help himself in bed". But examination reveals that the patient cannot help himself. He is paralysed with a polyneuritis. Urinalysis detects large quantities of porphyrins in every specimen, a case of "hematophorphyria".

The doctor's wife, "neurotic as heck", "hurts everywhere" and talks so much, fidgeting all over the bed, that a good examination is impossible. Yet one area seems more consistently painful, and a test-tube filled with ice chips localizes this zone exquisitely over the right pelvis. She is anesthetized and the gynecologist senses a wall of resistance in this region. Surgery reveals a carcinomatous infiltration, like a miliary spread. Was she neurotic? Yes, but organically sick, too! She required psychiatric, neurologic and gynecologic review to establish the pathology, an example of medical team work.

Last, but not least, are the administrative problems. One hospital patient calls the superintendent to inform him that he is coming down to shoot him. His claim — he was given the wrong ointment by the nurse for a mild dermatitis, (the charge was quite correct). Now he is itching and peeling, he will not pay his bill, and since the hospital has asked him to leave, he is coming down to shoot the superintendent. However, he permits a neuropsychiatric examination and turns out to have a, now-rare, general paresis. Furthermore, he is actually psychotic, despite the facts of the case; hence safe disposition for treatment is easy. Subsequent search of his clothes reveals a loaded automatic in a great-coat pocket. The threat was not idle.

In any general hospital the neuropsychiatrist is always busy, working alongside his colleagues, be they pediatrician, geriatrician, industrial surgeon, ophthalmologist or internist. He needs their help in his cases; they in turn need his. They now recognize neurologic and psychiatric factors in their cases, and ask for help. The neuropsychiatrist in turn must keep his foundation firmly in the groundwork of medicine. He must know the effect of fever and intoxication on the brain, of chronic debilitating disease on the ego defenses. He must be able to separate the organic from the functional, the genuine from the simulating. Most of all he must be able to sit down with his medical colleague so that together they may hammer out the problems which face the doctor every day.

OVERTREATMENT
As A Cause Of Disease
A Symposium

Dr. John S. Garvin
Assistant Professor
of Neurology

Dr. Adolph Rostenberg, Jr.
Professor of Dermatology
(Moderator)

Dr. Mitchell A. Spellberg
Clinical Associate Professor
of Medicine

Dr. Harry K. Waddington
Instructor in Obstetrics
and Gynecology

Dr. Max Samter: Diseases caused by overtreatment might be fault of the physician. The patient might induce illness by self-medication or over-the-counter prescribing. The physician might cause untoward results by the enthusiastic use of established drugs for conditions in which they are not indicated; or by the use of recently developed compounds which may have unpredictable side effects. Since the skin appears to be a favorite site for each and all of these sins, we have asked Dr. Rostenberg to induce and moderate this symposium.

Dr. Adolph Rostenberg, Jr.: There is no doubt that there is a need for discussion of this topic. The dermatologist sees large numbers of overtreated patients. Perhaps one reason for this is, as Pusey remarked: "Skin diseases occur on the surface of the body where everyone can see them but few can recognize them. Because of the first fact and despite the second fact, most physicians are inclined to treat them."

Basically, there are two types of overtherapy dermatitis. One is self-induced and the other physician-induced. They could also be classified as follows: (1) an exacerbation of the basic condition, (2) the development of a new dermatitis by (a) primary irritation, and (b) allergic sensitization. Primary irritation is nearly always due to the ignorance of a physician. There are three main pitfalls in the external treatment of skin diseases which I shall consider. The first is the vehicle in which the active agent is incorporated. This is extremely important. In contrast to other branches of medicine, the vehicle plays an important role in dermatologic therapy. The same agent in the same concentration but in two different vehicles can have very different therapeutic and/or irritative effects. The second is the state or stage of the condition. At different stages of the disease, one needs different therapy. The third illustrates a medical semantic difficulty. The physician fails to subclassify diseases that are listed together in a general category, as for example, eczema. It is a serious error to treat in the same fashion all cases of the same label. This may be illustrated with an example from internal medicine. Pneumonia is a general classification of a disease that occurs within the thoracic cage. However, pneumonia may be due to different organisms, for example: tuberculosis, Friedlander's bacilli, pneumococci, staphylococci, or streptococci, all of which require different types of therapy. A word as to the most overworked agents in dermatology: the antibiotics, steroids, local anesthetics, and topical antihistamin drugs.

SEMINAR
of the Department of
Medicine of the
University of Illinois
Edited by:
Dr. Max Samter
Associate Professor
of Medicine
Dr. Alexander Remenchik
Clinical Instructor
in Medicine

Dr. Mitchell Spellberg: Therapy more frequently involves the art of medicine than the science of medicine. The patient always wants the latest in therapy and the physician frequently is forced into the position of administering what is really unnecessary therapy. We must always hark back to the fundamental principles as first enunciated by Hippocrates: therapy must be harmless. This is especially true if the diagnosis is not known therefore, no specific drug is indicated. The present methods of medical education of the public are inadequate because they frighten the patient. It is better to educate the patient to appreciate the concepts of health rather than to frighten him with concepts of disease. One of the fundamental factors in the development of disease has been the progress in mass communication. The classic example of this is constipation and the use of cathartics which, in extreme cases may lead to the development of a cathartic colitis. There is no physiological evidence that one must move the bowel daily. However, this particular statement has been drummed into the public so that it is accepted as a physiological fact. The medical profession contributes to this phenomenon by prescribing more cathartics when the patient complains of constipation. There is no need in medicine for any cathartics except as preparation for gastrointestinal X-ray of the bowel, in the treatment of helminthiasis, and when one uses constipating drugs, for example, calcium salts or hexamethonium. An enema is the best method of ridding the colon of accumulated waste matter.

Another example of the development of disease due to therapy is the appearance of vitamin deficiencies or over-therapy with vitamins. One of the best examples of the former is the patient who was given a Sippy regimen of peptic ulcer and remained on it for many years and finally developed scurvy. Pathologic states may result from hypervitaminosis A and D.

One of the factors that we must combat is the demand of the patient for a prescription.

It is, therefore, important to convince the patient that the function of the physician is not to prescribe drugs but to give advice. In connection with this, attention ought to be called to the unwarranted use of antibiotics, particularly the broad spectrum antibiotics, for self-limited upper respiratory infections. There is adequate documentation of the fact that antibiotics produce gastrointestinal upsets which may be quite severe. I hasten to add at this point, that I do not believe antibiotics can be incriminated in the pathogenesis of ulcerative colitis for I feel that the cases that have been reported actually represent coincidental findings.

Dr. Rostenberg: Of all the instances of overtreatment, the use of barbiturates probably has received the widest publicity. Our next speaker, Dr. Garvin, will outline the problems of excessive sedation.

Dr. John Garvin: It is important to realize that a patient can get barbiturates without prescriptions—a reality which is responsible for most of our difficulties. The patient may take it upon himself to increase the dose of a sedative and to change from occasional to regular use. It is not uncommon for patients to take 20 to 30 tablets of a barbiturate prior to the development of a toxic psychosis. Bromide intoxication is in some ways more dangerous. The use of bromides is relatively common. On several occasions, I have seen bromide toxicity diagnosed as brain tumor or psychosis. I might mention here that not only exaggerated use, but also sudden withdrawal of therapy might cause complications. The sudden cessation of sedative medication will, on occasion, produce convulsions.

In the treatment of chronic diseases, the physician might cause unexpected illness in several ways: (1) of the anticonvulsive drugs, Dilantin® certainly is the safest for prolonged administration; even Dilantin, however, may produce moderate lethargy if given over prolonged periods at a high dosage level. Mesantoin®, on the other hand, is treacherous and may produce toxic effects such as agranulocytosis many months after the initiation of therapy; (2) In Myasthenia gravis, an overdose of prostigmine may product weakness which may be considered a result of inadequate dosage whereas an increase might produce toxic psychotic reactions; (3) In Parkinson's disease, patients may develop toxic symptoms from gradual accumulation of any drug. Fortunately, a psychosis of this type usually is preceded by premonitory symptoms, such as confusion.

Dr. Rostenberg: Shortly before the beginning

of the seminar, someone mentioned the strange situation that one-third of all estrogens are given by injection, despite the fact that they are clearly effective by mouth. I would like to ask Dr. Waddington to comment on the abuses of estrogens and of other drugs in his speciality.

Dr. Harry. K. Waddington: Estrogens are, beyond question, abused drugs. One must remember that the only acceptable indication for estrogens are the vasomotor symptoms of the climacteric — hot flashes and flushes. If needed, estrogens should be given orally and in small doses. From 0.1 to 0.2 mg of diethyl stilbestrol daily for a few months are an adequate dose for the vast majority of patients. Yet we see, on the average, one patient a month who needs a D & C because of overtherapy with estrogens and resulting uterine bleeding. Obviously, this is a grave complication because it may mask tumors; estrogens can produce an atypical endometrium.

While discussing the dangers of over-treatment in gynecology, I might caution against the routine use of broad spectrum antibiotics following surgery. We now see a large number of patients with monilial vaginitis a difficult condition to treat.

Dr. George Saxton (Associate Professor of Medicine): I would like to mention that over-treatment is not limited to drugs: oxygen and mechanical devices are not usually thought of in this manner, but might fall into the same category. I feel that a significant number of patients get into trouble because of the indiscriminate, long-term application of such aids.

Dr. Max M. Montgomery (Associate Professor of Medicine): I would like to submit a question to Dr. Garvin: Do you think that one-quarter of a grain of phenobarbital given over a long period of time is dangerous therapy?

Dr. Gilbert Kipnis (Research Assistant): I would like to supplement Dr. Montgomery's question: Do you actually consider a quarter grain of phenobarbital taken three times a day "therapy"?

Dr. Garvin: Yes, to both questions.

Dr. Robert Adolph (Assistant in Medicine): Is there any legal way to prevent pharmacists from usurping the function of a physician?

Dr. Rostenberg: Perhaps I can answer this question. Unfortunately the administrative staff of the Food and Drug Administration is much too small to supervise the sale of all prescription adequately. However, the prosecution of certain individuals has acted as a deterant for the few unethical pharmacists.

‹‹‹ ›››

Intestinal obstruction

More than 80 per cent of intestinal obstruction involve the small bowel. According to McIver's statistics, more than 70 per cent of all small bowel obstructions are accounted for by obstruction bands and hernias. Dennis states that about one-third of all obstructions in the small intestine follow abdominal surgery. He states that approximately 50 per cent of the cases are due either to postoperative adhesions or inflammatory adhesions; 35 to 40 per cent are due to external hernia strangulations; and the remaining 10 to 15 per cent arise from other causes. *Frank H. Hodgson, M.D., Intestinal Obstruction and Fluid Balance. Missouri Med., Feb.* 1955.

Early Illinois Medicine

James H. Hutton, M.D., Chicago

THE annual dinner of the Illinois State Medical Society was held in this very hotel 60 years ago. Governor Altgeld was a guest and wives of members were invited for the first time. Dr. E. P. Cook of Mendota called the meeting to order shortly after 10 p.m. They did not have the benefit of Dr. Reisch's services in getting started early.

There were many introductions and speeches. Mrs. Firebaugh, probably of Lawrenceville, told about the doctor's wife. Dr. John L. White, of Bloomington, was a member of the House of Representatives. He talked about medical statesman and pointed with pride, as indeed he could, to a public health bill passed by the House that day. Its purpose was to prevent a great deal of blindness in Illinois which it did. Late at night, my notes say, Governor Altgeld made a short address. Perhaps he was thinking of the hour and of the long program he had listened to when he said, "There is not a little thing in the State, unless it is the size of the Democratic majority at the last election."

It has been suggested that a brief look at the history preceding the creation of Dr. Cross's department might serve as a background for his talk. In earlier times medicine was less demanding. There were few journals, no libraries, no hospitals, no internships, no residencies, and no specialties, so that physicians had more time for outside activities. Consequently they took a more active part in community life. Six medical men signed the Declaration of Independence; and a Dozen took part as line officers in the battles of Lexington and Concord. General Joseph Warren, killed at Bunker Hill, was a physician and Warren County, Illinois, is named after him. They were not all patriots, however; Dr. Benjamin Church, Jr. of Boston, was our first spy.

In Illinois Dr. Fithian of Danville was a member of the legislature with Lincoln. The state was indulging in a spending spree — building railroads, canals, and what-have-you, which Fithian opposed. But when it was evident that these projects were going on anyway, he relaxed and decided to enjoy it by having much of the money appropriated for the Northern Cross Railroad spent in Vermilion County. His work was well done and eventually the Wabash Railroad used the right of way he had arranged.

Dr. W. R. Hamilton built and became president of the Peoria and Rock Island Railroad. Dr. John Evans built the Pennsylvania Railroad from the Union Station to the state line; also a line from Denver to connect with the Union Pacific. He founded Northwestern and the University of Denver. Evanston, Illinois and Evanston, Wyoming, are named after him as well as Mount Evans in Colorado. Silas Hamilton, of Otterville, in Jersey County left money for a school building and a teacher's salary. J. C. Goodhue is known as the father of Chicago's public school system. Dr. E. S. Kimberly was active in the Peoria convention which helped establish the state's public school system. Dr. Herman L. Victor Schroeder bought 80 acres from the Illinois Central, laid out a town, and called it Schroederville. It is now Gilman. Dr. Isaac Baker, with two other men, laid out Bloomington in 1831 and was its postmaster for many years.

Some physicians were editors. Dr. Brainard, who founded Rush Medical College and was one of the foremost surgeons of his time also was editor for a time of the Chicago *Democrat*. Dr. E. R. Roe was editor of the Jacksonville *Journal* and later the *Constitutionalist* and the Bloomington *Pantograph*. He was a lecturer on geology in state colleges and was partly responsible for the creation of the State Geological Department.

Some were active in politics. Dr. Roe was a

Preliminary remarks of Toastmaster, at the special dinner meeting honoring the Illinois Department of Public Health and Its Director, held in Springfield, February 8, 1955.

member of the 27th General Assembly and Dr. Wm. Henry Bissel of St. Clair County was inaugurated as governor January 12, 1957.

Mr. Paul Angle, the noted historian, for several years a resident of Springfield, has contributed a chapter called the "Hardy Pioneer" to our forthcoming Volume II of Medical History. He points out that Springfield did not get a public water supply until after the Civil War. For 20 years they discussed whether hogs should be allowed to roam Springfield's streets, arguing with the citizens the right of way on the boardwalks. Angle also quotes Dr. Daniel Drake's opinion of alcohol. People drank a good deal in those days and Dr. Drake disapproved, saying drinking caused disorders of the lungs, liver, and stomach, as well as sore eyes, swelling of the feet, epilepsy, and leprosy. Moreover, Drake said there was always the danger of spontaneous combustion.

Originally Illinois was part of Virginia. In 1778 the Virginia General Assembly created the County of Illinois. This was probably the largest county in the world, comprising what is now Ohio, Indiana, Michigan, Illinois, and Wisconsin. Patrick Henry, as Governor of Virginia, appointed John Todd as Lieutenant Commander of the district. In 1800 Illinois became one of the counties of Indiana. The Territory of Illinois was established in 1809.

There was little health legislation for this territory during that period. But in 1799 Madame Beulieu was health officer of East St. Louis, or Illinois Town, as it was then called. She issued a small pox quarantine regulation. (For this information I am indebted to Mr. B. K. Richardson of Dr. Cross's Department, who was one of the authors of a 2 volume history put out by that department in 1927). This regulation said that any one crossing the river was to be fined $6.00 for the first offense and $12.00 and ten days' imprisonment for the second. This was done to keep small pox on the Spanish side of the river.

In 1817 the Territorial Assembly, of which Dr. George Fisher, of Kaskaskia, was speaker, enacted a law which started out by saying "Whereas well regulated medical societies have been found to contribute to the diffusion of true service - - -". The state was divided into two districts, one east and one west of the third principal meridian. A medical society was provided for in each district to examine students and issue diplomas. If any one began practice without such a diploma, he was to be denied the service of the courts in collecting his bills. Apparently not much attention was paid to this law and in 1819 the first General Assembly of the State passed another bill which divided the state into four districts with a medical society in each. It provided also that all physicians should attend meetings. Failure to do so, without a valid excuse, made the doctor liable to a fine. The societies were to examine students, issue diplomas, and register births, deaths, and diseases.

Another section provided for the examination of bills rendered by physicians. If they were found to be exorbitant, the necessary adjustments were to be made and such surplus as might be unreasonably made was to be returned. It was like our modern Grievance Committee about which much is being written lately. Colorado recently inaugurated such a procedure and made quite a fuss about it. Illinois had it 136 years ago. The Chicago Medical Society has had such a committee continuously for more than 35 years.

This law evidently was ineffective. It was repealed in 1821 and a third law of similar intent was enacted in 1825, not much came of it. The doctors, individually and through their societies, continued to memorialize—that's what they called it—the legislature, praying for the creation of a State Department of Health. The legislature finally acted in 1877, but took a jaundiced view of the situation as evidenced by the size of the appropriation, $5,000 for the biennium.

While the effort to get this department was the central theme of their efforts. they also memorialized the legislature about other items. They wanted better state institutions. In 1867 they wanted a workman's compensation law. In 1876, Dr. J. H. Hollister complained about the coroner's law, as well he might, and as we still do. He thought that if the office was filled by a physician the situation would not be quite so bad. They wanted more humane laws regarding the admittance of the insane to state hospitals.

In 1897 the first osteopathy bill was introduced as SB297 by Senator Granger, of Chicago. There was much discussion during that annual meeting. Dr. Pettitt, of Ottawa, said he had

talked to Senator Granger, a nice pleasant old gentleman, a Christian Scientist. He had no interest in osteopaths, but thought if he could detour them around the medical practice act, he could do the same for others later. Dr. G. N. Kreider, of Springfield, thought the Society should adopt a resolution of protest. It did, and the legislature passed the bill with no dissenting votes. The Governor vetoed it. But the doctors debated among themselves as to whether and how much they should indulge in politics. They looked across the river to Iowa where there were 12 doctors in the Senate and half as many in the House. The osteopathy bill was easily defeated.

December 13, 1900 our Judicial Council (governing body of the Society) called on Governor-Elect Yates. Its members were introduced by Dr. Carl E. Black, of Jacksonville. They had spent a good deal of time debating what they should say, how they should say it, and who the spokesman would be. They finally elected Dr. O. B. Will, of Peoria, one of the most distinguished obstetricians of his time. His presentation to Judge Yates was a masterpiece of diplomacy. The council was dissatisfied with the medical men and medical services in state institutions and wanted to act as an advisory committee to the Governor in this matter. Judge Yates said he was glad to see doctors taking some interest in state government but they would be more effective if they worked in the primaries. Yates lived in Jacksonville where a number of state institutions were located and where ideas for most of the others originated, and knew state institutions as well as the physicians did. However, he would be glad to accept their offer to act in an advisory capacity, but reserved the right to disregard their advice if he so desired.

Shortly after Mr. Stevenson was elected Governor, a committee headed by Dr. Percy E. Hopkins called on him, asking that he retain Dr. Cross as director of the Department of Public Health. Undoubtedly every governor since Henry Horner has had the same request either from a committee or from the Council.

Dr. Cross is one of the great health officers of all time. We are here to pay tribute to him and his department. But in the process of doing so, we also are paying tribute to all you folks who run the state government. Without a friendly government environment, Dr. Cross could not have accomplished all that he has. Some of us have the strong feeling that public officials receive far too much criticism and too little commendation.

Most of you engaged in governmental services will agree that the State is something less than a generous paymaster. During the war, when Dr. Cross was busiest the salary scale was even lower. He could easily have made from two to 10 time as much in private practice. In addition to being underpaid, he was overworked because the armed services took a large percentage of his staff.

As an example of his efficiency, I cite the man with smallpox who crossed the river at Cape Girardeau headed for the munitions plant at Illiopolis. In some way, Dr. Cross found out about it, caught the man before he reached Illiopolis, and saved us a smallpox epidemic.

Everybody in the State of Illinois is indebted to Dr. Cross, his family, and his staff.

‹‹‹ ›››

BANQUET HONORS DEPARTMENT OF PUBLIC HEALTH AND ROLAND R. CROSS



Roland R. Cross, Director since 1940, receives citation from Arkell M. Vaughn, president, Illinois State Medical Society.



Mr. B. K. Richardson, Chief Administrative Officer for the Department accepted a citation from Joseph T. O'Neill, Chairman of the Council.



Andy Hall, Mount Vernon, delighted listeners with his remarks. He served as Department Director under Gov. Louis L. Emerson.



James H. Hutton, Chicago, was toastmaster at the banquet. His remarks (See page 174 in this issue) gave interesting facts about early medicine in the state.

The Illinois Department of Public Health

ROLAND R. CROSS, M.D., DIRECTOR

SO far as I know this is the first time that a voluntary professional organization has arranged a special event to publicly recognize a Department of the State government for having done a good job. I hope it represents a new trend in the relation of the people to their government. I appreciate it very much and I am glad of the chance to tell you a little about the Department of Public Health.

The State's public health agency, known now as the Department of Public Health, was established 78 years ago. That was in 1877. The proposal was formally initiated by the Illinois State Medical Society in 1876 and was accepted the following year by the General Assembly when the State Board of Health was created by law. It turned out in the course of time to be an excellent investment.

During its first 25 years the State Board of Health was not able to prevent measurably the spread of any epidemic disease except smallpox. There wasn't much that could have been done. Nobody knew how to prevent such diseases other than smallpox. During that period scientists first discovered for sure that microscopic germs are the cause of communicable diseases. It wasn't easy and it took a long time to learn how to use that new knowledge advantageously in the prevention of diseases. Thus the State Board of Health made no headway against communicable diseases in the first 25 years except for smallpox. It laid only the foundation for future work and it made plans in the light of the unfolding knowledge about the causes of contagious diseases.

The General Assembly recognized the situation for exactly what it was. They gave the State Board of Health $5,000 with which to operate during its first biennium. In 1901, when the news about the discovery of the germs that cause diphtheria, tuberculosis, typhoid fever, and some other diseases had got around, the biennial appropriation for ordinary operating expenses was $45,000. The Board had successfully survived a difficult infancy.

The next 25 years were not easy. Doctors, health officers and other scientists sought almost feverishly for good ways to use the new knowledge about disease germs so as to prevent epidemics. Antitoxin for the treatment of diphtheria was an early method that helped cure the disease. A vaccine against typhoid fever was developed. A drug that cured syphilis after prolonged treatment was made available. Many other preparations were brought forth and tried. The chlorination of water and the pasteurization of milk came into practice here and there during this period.

By 1927, when the State Board of Health had given way to the State Department of Public Health and the agency was 50 years old, the tools of public health service had been forged. It had been learned through agonizing reappraisal of many prescriptions that there is no single way to fight epidemic diseases successfully; that every disease germ is different from any other and must be fought in a particular way. Some diseases like diphtheria and whooping cough, for example, could be prevented by immunizing people so that infection would not harm them. Others, like typhoid fever, could best be prevented by killing off the germs ahead of infection by such things as pasteurization and chlorination. Still others, like tuberculosis, could be dealt with most effectively by restricting infected persons so that they would not spread the germs to others. The best that could be done with respect to certain other diseases, like syphilis, was to kill the germs in the bodies of infected persons by the use of drugs. Some, like malaria and yellow fever, could be prevented by the destruction of insects.

This address was given by Dr. Cross on February 8, 1955, at a dinner meeting arranged by the Illinois State Medical Society to honor the Illinois Department of Public Health, and its Director. The meeting was held at the Leland Hotel, Springfield. More than 130 members of Illinois Legislature and state officials were present.

Thus the end of the second 25 years in the history of the State's public health agency found the health officer and the doctor for the first time on really solid ground in a campaign to prevent communicable diseases in a wholesale manner. It was a complicated technical business which required the services of highly trained professional people but the way was clear and the methods sure for rapid progress ahead. Up to this time not much had actually been accomplished in Illinois by way of preventing communicable diseases. Raging epidemics of diphtheria, whooping cough, and scarlet fever still prevailed. Hardly a dent had been made in tuberculosis. Only the bold and the venturesome dared mention the venereal diseases in public or in polite conversation. The 50 years had been a period of preparation for health departments but they were now really ready to go.

The past 25 years has been a period of achievement for public health service in Illinois. During this time a strongly favorable public opinion has prevailed. The General Assembly has been sympathetic with respect to both appropriations and needed legislation. More and more trained personnel has been available to fill professional and technical positions. Voluntary organizations and agencies such as the Illinois medical societies, dental societies, nurses associations, hospital associations, tuberculosis associations and those devoted to cancer, heart disease, crippled children, and other special problems have been most cooperative in the general public health program. Only so could the remarkable progress which has marked the course of public health in Illinois have taken place.

Some of the many specific things done during the last 25 years are worthy of mention. In the mid-thirties, for example, a formalized training program financed by the Department of Public Health was adopted and has produced about 1,000 well trained public health workers for Illinois.

In 1940 a cancer control program was initiated by the establishment of diagnostic centers in various hospitals throughout the State. About 4,000 persons are examined annually at the 28 centers now in operation which also serve as educational centers for local practicing physicians.

In 1942 the American Public Health Association made a comprehensive survey of the Department of Public Health and the public health needs of the State. Recommendations which came out of that study made an excellent guide for the reorganization of the State's public health machinery and for the long term development of public health service. One particularly important result was the enactment in 1943 of the law which permits the establishment of county and multiple county health departments. The people in 27 counties have voted by large majorities to take advantage of this law and now enjoy the benefits of fulltime public health service.

Down-state Illinois has 3 centers for the care of premature babies which are unexcelled anywhere in the quality for service rendered. They are located in hospitals at East St. Louis, Springfield, and Peoria. They were established about 10 years ago through encouragement by the Department of Public Health which provided some of the special equipment and helped to train the personnel. It has underwritten from the outset the cost of caring for the babies admitted which now number more than 800 per year. The survival rate has been very good among babies cared for in these centers which have served also as training centers for other hospitals.

In the mid-forties the Department started for the first time to participate substantially and aggressively in the tuberculosis control program in Illinois. Since that time the State has constructed and is operating two modern tuberculosis hospitals, one of 485 bed capacity at Chicago and another with 100 beds at Mt. Vernon. The State now provides also $2,500,000 annually for grants-in-aid to local tuberculosis sanatorium boards which are unable to meet their obligations through required tax levies. The Department also contributes heavily to a Statewide case-finding campaign which provides chest x-rays to upwards of 1,000,000 persons every year. The effect of this stepped-up program is a remarkable improvement in mortality from tuberculosis which declined from 40 per 100,000 people in 1945 to 14 in 1953 and an estimated 11 in 1954. This is a reduction of about 72 per cent in less than 10 years.

Another no less fruitful project relates to syphilis. During the early forties the Department participated in the experimental use of new drugs for the rapid treatment of that disease.

After successful experience the Department made the new drugs available free and thereby encouraged the swift change in treatment practice. At that time the Department employed 40 part-time doctors, 28 fulltime nurses, and 7 fulltime investigators. It operated 30 odd clinics devoted entirely to venereal diseases. Syphilis reached peak prevalence in 1943 with upward of 28,000 cases reported. Last year less than 5,000 cases were reported. All clinics operated by the Department have been closed for shortage of business and the personnel reduced accordingly.

The biggest single operation of the Department during recent years is the administration of the Community hospital construction program which began in 1947. To date 52 construction projects with an aggregate of 4,041 beds have been authorized at an aggregate cost of about $73,000,000. Many of these hospitals, of which 35 are now in operation, are located in communities which previously had no hospitals at all or only obsolete and inadequate facilities. No finer hospitals and none more serviceable are to be found anywhere than the chain of hospitals built in this program. And there are more to come.

More closely associated with the medical profession than any other activity are our laboratory services. Although housed more poorly than those of almost any other state, our laboratories perform work on a quality second to none and stand well in the front ranks of progress in technical advancement and in research. Indeed one piece of research done jointly with others by our laboratory resulted in an improved method of producing vaccines which has been widely adopted nationally. Another is the development of a polio vaccine more promising than any other polio vaccine brought forward up to now.

The Department's program in sanitation has been extended and intensified, especially in respect to milk supplies and the abatement of pollution in streams. Extensive mileage of important streams has been practically freed from dangerous pollution while Illinois grade "A" milk supplies are accepted generally in inter-State commerce.

The citations I have given illustrate the character of work done in many other lines such as in dental health, nursing, education, maternal and child hygiene, nutrition and statistics. These multiple activities all contribute to the improvement of health throughout the population.

How has the kind of investment represented by the development of the Department of Public Health paid off? Well, in 1930 a group of 13 communicable diseases — including diphtheria, dysentery, infantile diarrhea, influenza, measles, meningitis, pneumonia, scarlet fever, smallpox, syphilis, tuberculosis, typhoid fever, and whooping cough — caused 190 deaths per 100,000 of the population in Illinois. In 1953 only 58 deaths per 100,000 were attributed to that group of diseases. Indeed diphtheria and typhoid fever caused only 1 death each in 1953 while 1954 was the seventh successive year in which no case of smallpox was reported in the State. The loss of mothers from complications of childbirth approached the vanishing point in 1953 with 5 deaths per 10,000 births against 54 in 1930 and 70 in 1921. The infant death rate was 26 per 1,000 births in 1953 against 56 in 1930 and 81 in 1921. The average life expectancy at birth in Illinois was about 57 years in 1920, about 60 in 1930, and about 70 now. Most of this longer expectancy has been tacked on to the lives of persons under 60 years of age. Obviously the extension of life expectancy by 10 years since 1930 for the 9,000,000 people in Illinois, on the average, adds tremendously to the productive power in our State.

These are the kinds of dividends paid by public health service and the practice of preventive medicine. It is a program in which nearly everyone participates and which requires a high degree of cooperation and teamwork between many individuals and agencies, public and private, official and voluntary. Public health service has given a good account of itself in the past. The potentialities of the future are even better.

Treatment of Comedones in ACNE VULGARIS With High Frequency Current

WILLIAM A. ROSENBERG, M.D., Chicago

COMEDONES often develop in individuals who are afflicted with "oily skin", a condition which is recognized clinically as seborrhea oleosa. By the increased secretion of the sebaceous glands and the pressure of the growing hair at puberty a hyperkeratosis of the funnel of the follicles is caused, and this results in the formation of the comedo.[1] The comedo plug blocks the outlet of the duct of the sebaceous gland and prevents the pent up sebum from escaping thereby causing the gland to undergo cystic distention. Secondary infectious processes of the tissue surrounding the comedones produce the inflammatory nodules. These lesions may be absorbed; however, the inflammatory processes often increase and pustules are formed which heal by cicatrization.

Young women afflicted with persistent comedones and acne vulgaris often develop superfluous hair as a concomitant symptom. Nomland[2] observed and reported a group of such cases in women between the ages of 22 and 30. In treating cases of hypertrichosis with high frequency current for epilation, I observed, and the patients frequently remarked, that both the oiliness of the skin and the acne lesions decreased. This observation led me to employ the high frequency current as used for epilation[3] in the treatment of comedones in acne vulgaris.

HIGH FREQUENCY CURRENT

The high frequency oscillating unit contains a thermionic vacuum tube connected in an appropriate circuit of inductance and capacities, and produces approximately 10 million cycles per second (Figure 1). The oscillating unit is coupled with an automatic electronic timer which limits the application of the high frequency current to one-twentieth of a second.

TECHNIC

The vacuum tube diathermy machine transmits sufficient energy to permit employment of the monoterminal method.[4] A fine straight needle, .005, with an oval bulbous tip is fixed into the needle holder which is connected to the unit. The needle is inserted at an oblique angle into the mouth of the follicle for about 3 mm. It is of utmost importance that the needle be inserted deep enough to reach the sebaceous gland. A binocular loupe helps greatly because it magnifies and leaves both hands free. The operator closes the circuit by stepping on the foot switch, thus allowing the oscillating current to flow to the needle. The automatic timer then shuts off the current in one-twentieth of a second. From the initial low intensity, the current is gradually increased by a master control

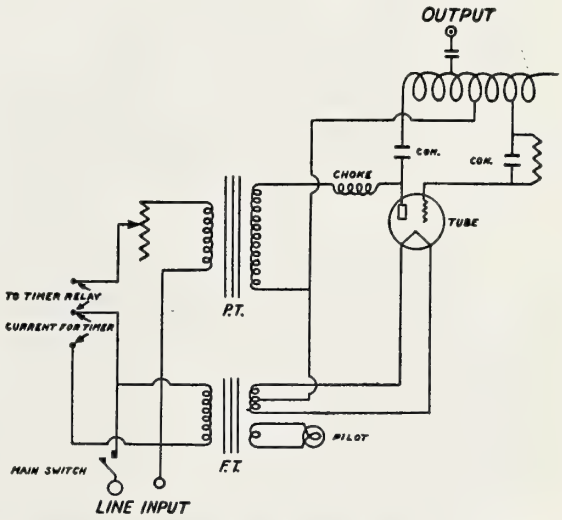


Figure 1.—Vacuum tube hook-up for treatment of comedones.

From the Department of Dermatology, Chicago Medical School.

in order to establish the proper threshold of current required to shrink the sebaceous gland. Since several sebaceous glands may empty into the mouth of the follicle, more than one exposure may be required. The comedones so treated will disappear in approximatey three weeks, leaving no atrophy or cicatrization.

Thirty-nine cases of acne vulgaris were treated with this method and were observed over a period of six months to three years. The type of acne, and the response to treatment in these cases were as follows:

The first group treated consisted of six patients who had received various forms of local therapy including x-rays with unfavorable results. The following two cases were typical of this group:

Case 1.—D.K., a boy 20 years old, was referred to me by his family physician on August 11, 1950. Examination at that time showed a wide spread acneform eruption of eight years duration on the face. Individual lesions consisted of numerous comedones, papules, pustules, scars, and a persistent hyperemia of the flush part of the face. The patient gave a history of having had various forms of local therapy, vaccines, and x-rays. He was then treated twice weekly with the high frequency current, and at the end of 12 weeks the erythema and acneform eruption had practically disappeared.

Case 2.—J.K., a boy aged 18, was first seen by me on October 10, 1950. He stated that he had acne vulgaris for four years and had received various forms of local therapy, vaccines, and fifteen roentgen treatments. Examination showed a wide spread acne vulgaris on face and neck. The predominating individual lesions consisted of comedones, pustules, and cystic lesions, especially about the bearded region of the neck. He was treated with the high frequency current once a week, and after twelve exposures there was a marked improvement, the cysts having practically disappeared.

The second group treated were nine patients between the ages of 12 to 16 who previously had been given local therapy. Since their parents were fearful of x-rays, they readily accepted the treatment with the high frequency current. The patients had moderate to severe forms of acne, consisting of numerous comedones, papules, pustules, and cystic lesions. Seven of the cases in this group showed excellent results; two had a mild recurrence a year later which responded favorably to further similar treatment.

The third group comprised ten cases of women between the ages of 21 to 30 who had received various forms of therapy. All had oily skin, persistent comedones, scars, recurrent acneform lesions, cysts, and hypertrichosis. This group responded favorably to the high frequency therapy, especially when the hypertrichosis was treated. The following case was typical of this group:

Case 3.—H.S., a white woman, 30 years old, was first seen on August 10, 1949. She complained of superfluous hair on the bearded region and upper lip of six years duration. Examination showed numerous pitted scars, scattered comedones, and acneform lesions on the cheeks. The patient gave a history of having a severe case of acne vulgaris, which began at the age of twelve, for which she received local therapy for about eight years with unfavorable results. She was then advised to have twelve Roentgen treatments. There seemed to be considerable improvement of the acne following the Roentgen exposures. At the age of 22 the hypertrichosis on the face became conspicuous, and there was an associated recurrent acneform eruption on the bearded region. The hair was removed with the high frequency current, and the acneform lesions were treated as outlined in the technic. One year after treatment there was practically no recurrence of the acne or the hypertrichosis.

The fourth group consisted of six cases of severe acne of the face, neck, and back, of many years duration. Besides the usual lesions of acne there were numerous double comedones, keloidal fibrous bridges, large cysts, deep indurated nodules and sluggish abscesses. The comedones in these cases were treated as described in the technic; the bridges over the double comedones were cut open with the high frequency current, the comedones expressed, and the base treated with the energized needle for a fraction of a second. The cut surfaces healed leaving no visible scars.

The fifth group consisted of four males and four females varying in age from 17 to 20 years. They had numerous comedones, pustules, nodules, scars, and marked inflammatory processes. In addition to the treatment of the comedones with the high frequency current this group was given concomitant roentgen therapy (a dose of 40 r per week) for 12 weeks. These cases responded excellently to the combined form of therapy.

HISTOLOGIC STUDY

Specimens of tissue were taken four weeks after treatment for histologic study. Figure 2 shows histologically that four weeks after treatment no trace of the comedo or horny mass remained, the follicular orifice completely closed, and the sebaceous glands shrunk so that they are not visible in the field. There is, however, very little increase in the connective tissue in the inflammatory infiltrate is rather dispersed and

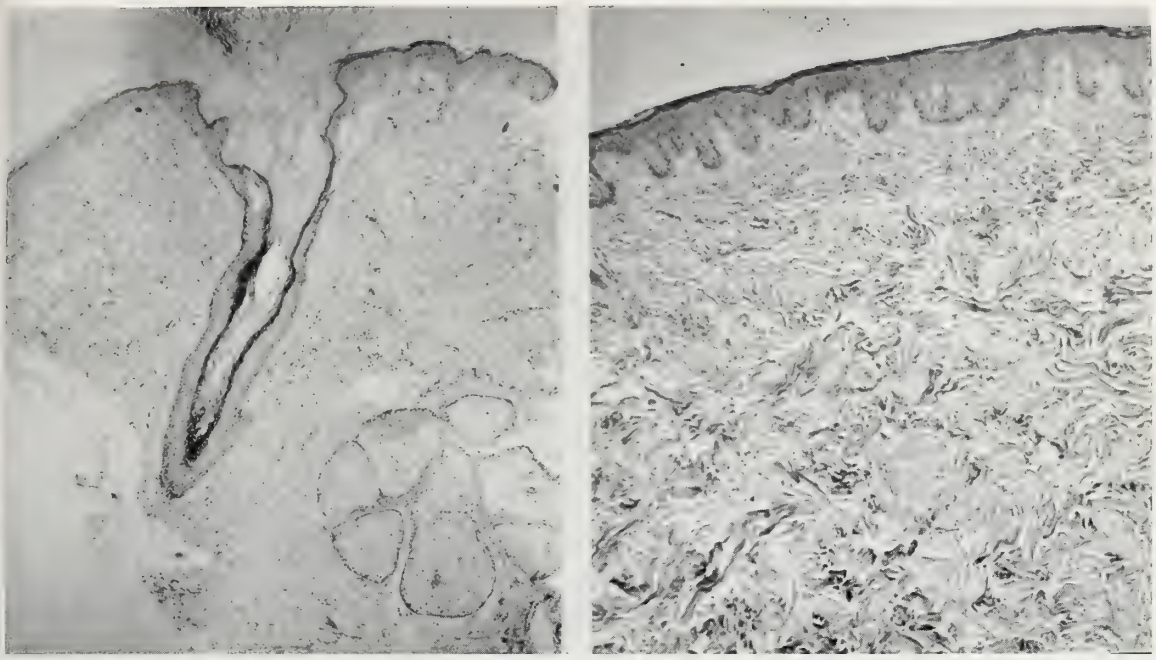


Figure 2.—(a) Photomicrograph of a comedo in acne vulgaris. (b) Section taken four weeks after treatment of a comedo shows no trace of comedo and the follicular orifice is completely closed.

vicinity of the destroyed glands or follicles. The the average number and type of cells are present in the corium.

SUMMARY AND CONCLUSION

Thirty-nine cases of various types of acne vulgaris were treated with the high frequency current with beneficial results. In cases of acne vulgaris associated with marked seborrhea oleosa the treatment was combined with small doses of x-ray (a dose of 40 r. per week) for twelve weeks. Women having persistent and recurrent acne vulgaris often develop hypertrichosis; this group responded favorably to the high frequency therapy especially when the hypertrichosis was treated. The thirty-nine patients treated and observed over a period of three years showed no scar formation or other untoward changes in the skin.

185 N. Wabash Ave.

BIBLIOGRAPHY

1. Macleod, J.M: Practical Handbook of the Pathology of The Skin, London, H.K. Lewis, 1903, p.82.
2. Nomland, R.: Treatment of Acne Vulgaris With Comedos By Monoterminal Electrodessication, Arch. Dermat. & Syph. **48**:302-304 (Sept.) 1943.
3. Rosenberg, Wm. A. and Smith, Edwin M.: Removal of Superfluous Hair With the Cutting Current, Archives of Physical Therapy, May, 1943, Vol XXIV, pp. 277-279.
4. Brown, Marthe Erdos: Superfluous Hair, Removal With the Monopolar Diathermy Needle, Arch. Dermat. and Syph. **46**:496 (Oct.) 1943.

EDITORIALS

B_{12} problems

Vitamin B_{12} is not absorbed readily from the stomach and intestines. Pernicious anemia would not develop if the individual were able to transfer a millionth of a gram of vitamin B_{12} a small fraction of a millimeter. This is the distance between the gastrointestinal mucosa and the blood stream. These patients lack a special component of gastric juice — the intrinsic factor — which is so necessary for vitamin B_{12} absorption.

Glass and his associates[1] demonstrated the presence of another factor that governs the amount absorbed by using vitamin B_{12} tagged with radioactive cobalt. When 0.5 mcg. of this material was taken orally, the percentage that reached the liver was almost the same (90.5) as that of an intramuscular injection of a similar amount.

With increasing doses, however, the quantity absorbed fell to such an extent that only 3 per cent reached the liver when 50 mcg. were given by mouth. They estimated that 0.45 mcg. reached the liver when 0.5 mcg. was taken but only 1.5 mcg. following a 50 mcg. dose. In this respect, the stomach or intestine harbors a factor that governs the amount absorbed in keeping with the needs of the body for vitamin B_{12}.

The results of parenterally administered vitamin B_{12} are standing up under the most critical evaluation. Schwartz, Friedman, and Gant[2] conducted a long term survey of 51 pernicious anemia patients treated in this way, of whom 32 were observed four years or longer on 30 mcg. every four weeks. There was no evidence of hematological relapse. Four showed an unequivocal neurological relapse. Three of these patients improved rapidly when the dosage was increased. Findings revealed that 1 cmg. daily was not enough to sustain neurological integrity; neither were larger doses given too far apart.

The dose that prevents relapse must be large enough to overcome the effects of excretion and depletion. The authors mention that from 50 to 68 per cent of an injected dose is excreted in the first 18 to 48 hours. The remainder is utilized slowly or is stored in the tissues. An inadequate amount, administered at 2 week intervals, usually leads to a deficiency. When larger doses are given initially, the amount stored in the tissues may increase sufficiently to permit smaller injections without jeopardizing the hematologic or neurologic status of the patient.

1. G. B. Jerzy Glass, L. J. Boyd, and L. Stephanson. Proc. Soc. Exp. Biol. Med. 86:522 1954.
2. Steven O. Schwartz, M.D., Irving A. Friedman, M.D., and Helen L. Gant. J.A.M.A. 157:229 (Jan. 15) 1955.

The 1955 annual meeting

The preliminary program for the 115th Annual Meeting of the Illinois State Medical Society to be held at the Hotel Sherman, Chicago, on May 17-20, is published in this issue of The Journal. The complete, official program will appear in the May Journal, which will go on the press early enough to be in the hands of the members of the State Society by May 10.

Those responsible for the arrangements, programs, and other functions, have been working diligently over a period of months to develop their programs, to make the 1955 Annual Meeting an exceptionally fine one. It is hoped that the members throughout the State of Illinois will keep this meeting in mind, and arrange to be present May 17-20.

It is recommended that those desiring to

attend the meeting, arrange in advance for suitable hotel accommodations. These may be procured by writing to Mr. Earl R. Benedict, Convention Manager, Hotel Sherman, Chicago. PLEASE MARK THE DATE ON YOUR CALENDAR AND ARRANGE TO BE PRESENT AT THIS FINE MEETING.

‹ ›

Continued growth of Illinois Medical Service

On August 15, 1954, the Illinois Medical Service Blue Shield Plan increased benefits at no extra cost to members for the second time in three years. The maximum for in-hospital medical care was increased from $180.00 in any calendar year to $220.00 in a 70 day period; allowances for certain surgical procedures in the doctor's office were added. X-ray, pathology and anesthesia benefits were increased; allowances for certain surgical operations were raised, and emergency accident hospital care allowance was added. In addition the single rate on group certificates was reduced 25 per cent.

During the year 1954, 154,559 members were added, bringing the membership to well over the million mark—1,084,573 members December 31, 1954. This represents a 17 per cent increase over the 930,014 members on December 31, 1953. In spite of the reduction in the group single rate, income from members increased from $8,464,911 in 1953 to $9,617,819 in 1954. Benefits increased even more . . . payments to physicians amounted to $7,462,589 compared to $6,202,968 during the previous year; an increase of 20 per cent. During 1954, 140,804 cases were paid as compared to 115,679 in 1953. Total payments since the inception of the plan in 1947, amount to $23,165,300 on 439,224 cases. The reserve for future medical care increased from $4,391,767 to $5,700,000, or from $4.87 to $5.42 per member.

The continued growth of the Illinois Medical Service Plan should be considered substantial evidence of the acceptance of the pre-payment principle by the residents of Illinois. With the continued growth of similar plans in the many other states, it seems quite obvious that our American people are becoming more thoroughly aware of the fact that the voluntary plan for providing for the unexpected medical or surgical care can give them adequate protection for most illnesses or accidents. Those responsible for the operation of the Illinois Medical Service Plan, have done a fine job, and they have enjoyed the cooperation of the medical profession of the state of Illinois in this big undertaking. In summarizing their annual report of progress, the officers and Executive Director of the Plan desire to thank the medical profession for their continued cooperation.

‹ ›

Statistics

Are we careless with statistics? Schwade and Otto[1] are of the opinion that we are. They cite the reported figures on total deaths caused by epilepsy as an example. The Wisconsin State Board of Health attributed 70 deaths to epilepsy but a more thorough investigation revealed that 44 of the group were caused by lung, heart, or circulatory diseases, or a variety of other conditions unrelated to epilepsy. This means that the death rate was not 2 per 1,000 but 1 per 1,000 and indicates that epilepsy is not a common or frequent cause of death in Wisconsin.

‹ ›

Another Illinois physician honored by his home community

Approximately 400 persons attended an appreciation dinner held at Mackinaw, Illinois, on Wednesday evening, February 23, 1955. The honored physician on this occasion, was Dr. H. D. Fast, who has served the community for almost fifty years. After his graduation from the University of Illinois College of Medicine, Dr. Fast located at Mackinaw in 1906. Intending to remain there for only a few years, he rapidly became a part of the community, was married there in 1909, and he and Mrs. Fast were the devoted parents of three children. Two married daughters live in Albuquerque, New Mexico, and in Long Beach, Indiana. A son, Major Robert D. Fast, was killed in a plane crash overseas, during World War II.

Dr. Fast served with the Medical Corps in World War I, returning to Mackinaw after his separation from service. He has always been active in the affairs of his country and State Medical Societies, and as a member of the A. M. A. He has been medical director of

[1]Edward D. Schwade, M.D. and Owen Otto, M.D., CORRESPONDENCE. J.A.M.A. 156:1526 (Dec. 18) 1954.

Oak Knoll, Tazewell County Tuberculosis Sanatorium since 1923, and he is a member of the American College of Chest Physicians and of the Trudeau Society. Believing that a physician should be associated with all community activities, he has been president of the village board, director of their National Bank, and a member of the Mackinaw school board.

The appreciation dinner and program were presented in the high school gymnasium. Many presents were given to Dr. and Mrs. Fast following the dinner. The principal address was made by Dr. F. Garm Norbury, President-elect of the Illinois State Medical Society, who brought greetings from the nearly 10,000 members of this Society to a man who has served his community well for a long period of time, and who has done a fine job. Dr. Norbury commended Dr. Fast on his advancement with the treatment of illness, commenting on the many advances in medical care over this long period, which have necessitated changes in care on the part of the attending physician for many illnesses. He also referred to the willingness of the doctor to give his time with other citizens, to study the many community problems not directly referable to the practice of medicine.

Dr. Fast expressed his appreciation for the tribute given to him by so many of his friends, and told them that he had long ago discovered he had selected the right town to conduct his practice and become a part of the community.

Each year in a number of Illinois communities deserving physicians who have served their communities well over a long period of time, are being honored by their appreciative patients and friends, and invariably it is indeed, a well deserved tribute.

‹ ›

Dr. Warren W. Furey receives another honor

Dr. Warren W. Furey, Chicago radiologist, was recently elected as the 32nd President of the American College of Radiology. Dr. Furey, a native of Chicago, graduated from the Northwestern University Medical School in 1923. He is assistant professor of radiology at the Stritch College of Medicine of Loyola University, Chicago, and he also serves as radiologist-in-chief to Little Company of Mary and Mercy Hospitals in Chicago.

He is Chairman of the Illinois State Medical Society Committee on Constitution and By-laws, and has served for several years, as Parliamentarian for the meetings of the House of Delegates during the Annual Meetings. Dr. Furey, a Past President of the Chicago Medical Society, is also a member of the A. M. A. House of Delegates from the Illinois State Medical Society.

He is also a past-president of the Radiological Society of North America, and recently was awarded that Society's Gold Medal for his outstanding services in radiology.

‹ ›

Dedication of the suburban Cook County Tuberculosis Hospital

Dedication of the nation's newest tuberculosis hospital-sanatorium took place March 6, when directors of The Suburban Cook County Tuberculosis Sanitarium District officially opened the $3,500,000, 174-bed institution at 55th and County Line Road, Hinsdale.

The new plant, which will house 154 tuberculosis patients in the main building and 20 convalescent patients in another, will provide care for citizens of the suburban Cook County area who were formerly placed in outlying sanatoria through a contractual arrangement with the District.

First group of patients, transferred from Zace Sanitarium, Winfield, were moved to the new hospital-sanatorium on February 14.

The three story red brick structure will house patients on three "y-shaped" wings, with most of them in single rooms. The nursing station is located at the notch of each "y", and day rooms are located at the ends. Two-way communications systems provide for constant contact between patients and nurses, and each room is equipped with modern all-steel furnishings. Rooms are decorated in an attractive homelike manner.

Two air-conditioned surgical units, well-equipped pathological, biological and research laboratories, and a chapel-auditorium are other highlights of the new institution, which will also house District administrative offices.

A two-story personnel building will provide quarters for approximately half the nursing and other employees, and residential units are provided for the chief of staff and hospital administrator.

PROGRAM

One Hundred Fifteenth

Annual Meeting

Illinois State Medical Society

Hotel Sherman **Chicago**

May 17, 18, 19, 20,
1955

Program Summary

TUESDAY, May 17
In the Morning:
- Section on Anesthesiology — Room 104
- Section on Eye, Ear, Nose and Throat — Assembly Room
- Section on Cardiovascular Disease — Room 114
- Section on Obstetrics and Gynecology — Room 101
- Physicians' Association — Room 113
- FIRST MEETING OF THE HOUSE OF DELEGATES — Louis XVI Room

At noon:
In the Afternoon:
- GENERAL ASSEMBLY in the Ballroom
- Section on Radiology at 3:30 p.m. in the Crystal Room

In the Evening:
- Public Relations Dinner — Room 101
- HOSPITALITY HOUR — (9:00 p.m.) Bal Tabarin on Sixth Floor

WEDNESDAY, May 18
In the Morning:
- Women Physicians' Breakfast at 8:00 a.m. — Room 113
- Section on Surgery — Room 101
- Section on Pediatrics — Louis XVI
- Section on Eye, Ear, Nose and Throat — The Assembly Room
- Section on Pathology — Room 104
- Illinois Chapter, American College of Chest Physicians — Room 114
- Meetings of the Reference Committees of the House of Delegates

At Noon:
- Luncheon for the Section on Surgery — Room 101
- Luncheon for the Section on Pathology — Room 104
- Luncheon for Illinois Chapter, American Academy of Pediatrics — Louis XVI Room
- FIFTY YEAR CLUB LUNCHEON — Assembly Room
- Luncheon — Illinois Chapter, American College of Preventive Medicine — Room 103

In the Afternoon:
- GENERAL ASSEMBLY in the Ballroom

In the Evening:
- THE ANNUAL DINNER honoring Dr. Arkell M. Vaughn, President — Ballroom

THURSDAY, May 19
In the Morning:
- Section on Allergy — Room 114
- Section on Medicine — The Assembly Room
- Section on Dermatology — Room 101
- Section on Preventive Medicine & Public Health — Louis XVI Room
- Any additional meetings of Reference Committees of the House of Delegates

At Noon:
- Phi Chi Luncheon — Room 107
- Luncheon for the Section on Dermatology — Room 101
- Luncheon for the Section on Allergy — Room 104
- Luncheon for the Section on Preventive Medicine & Public Health — Louis XVI Room

In the Afternoon:
- GENERAL ASSEMBLY in the Ballroom
- SECOND MEETING OF THE HOUSE OF DELEGATES at 3:30 p.m. in Louis XVI Room

In the Evening:
- Loyola Alumni Dinner — Crystal Room
- Phi Beta Pi Smoker — Abbott Hall

FRIDAY, May 20
In the Morning:
- THIRD MEETING OF THE HOUSE OF DELEGATES at 8:30 a.m. in Louis XVI Room
- Scientific Movies in the Crystal Room
- The meeting closes officially at noon on Friday

In the Afternoon:
- Illinois Association of Blood Banks

An Extract from the Constitution and By-Laws

CHAPTER XIII

SECTION 3. All papers read before the Society or any Section thereof, shall become the property of the Society. Each paper shall be deposited with the Secretary when read, and presentation of a paper to the Illinois State Medical Society shall be considered tantamount to the assurance on the part of the writer that such paper has not already been published.

Meetings of the House of Delegates

The Outstanding General Practitioner for 1955, H. O. MUNSON of Rushville, will be honored at the first meeting of the House of Delegates to be held on Tuesday morning, May 17, in the Louis XVI Room.

THE FIRST MEETING OF THE HOUSE OF DELEGATES

The Louis XVI Room
9:00 a.m. TUESDAY, May 17, 1955

The first meeting of the HOUSE OF DELEGATES will be called to order by the President, Arkell M. Vaughn of Chicago for:

The appointment of Reference Committees;
Reports of Officers, Councilors, Committees, etc.
Introduction of Resolutions

and for the transaction of any other business which may come before the House.

THE COMMITTEE ON CREDENTIALS will meet at 8:00 a.m. on Tuesday morning, May 17, in the entrance way to the Louis XVI Room. Delegates desiring to be certified as the official representatives of their county medical societies must present their credential cards to this committee.

THE SECOND MEETING

The Louis XVI Room
3:30 p.m. THURSDAY AFTERNOON, May 19, 1955

The Second Meeting of the HOUSE OF DELEGATES will be called to order by the President to hear those reports which are ready to be presented.

THE THIRD MEETING

The Louis XVI Room
8:30 a.m. FRIDAY MORNING, May 20, 1955

The Third (and last) Meeting of the HOUSE OF DELEGATES will be held Friday Morning, May 20, at 8:30 a.m., in the Louis XVI Room to:

Hear those reports remaining to be presented
For the Election of Officers, Councilors, Committees, Delegates and Alternates to the American Medical Association;

and for the transaction of any other business to come before the House.

At the close of this last meeting, F. GARM NORBURY of Jacksonville, will be installed as the new President of the Illinois State Medical Society, and will receive the official gavel from the retiring President, Arkell M. Vaughn of Chicago.

Scientific Programs Scheduled for the First Day of the Meeting

Tuesday, May 17, 1955
SECTION ON ANESTHESIOLOGY

CHAIRMAN ..... Ernest F. Kreutzer, Joliet
SECRETARY ..... Arthur T. Shima, Oak Park
ALTERNATE ..... E. M. Dewhirst, Danville

TUESDAY MORNING, May 17, 1955
The Emerald Room — No. 104

9:00- 9:10 Opening — Chairman

9:10- 9:30 "Alcohol Inhalation in the Treatment of Acute Pulmonary Edema in the Immediate Post Operative Period"
RUTH WEYL, Associate Professor of Anesthesiology, Chicago Medical School; Director of Anesthesiology, Mount Sinai Hospital, Chicago

9:30- 9:50 "Reaction to Local Anesthetic Drugs"
RAYMOND F. ROSE, Clinical Instructor in Anesthesiology, University of Illinois College of Medicine, Chicago
MAX S. SADOVE, Professor of Surgery, University of Illinois College of Medicine; Head, Division of Anesthesiology, Research and Educational Hospitals, Chicago

9:50-10:10 "Anesthesia Management of the Bad Risk Patient for Transurethral Prostatic Resection"
CONSTANCE L. GRAVES, Staff Anesthesiologist, Wesley Memorial Hospital, Chicago
MARY KARP, Assistant Professor of Surgery, Division of Anesthesia, Northwestern University Medical School; Director of Anesthesiology, Wesley Memorial Hospital, Chicago

10:10-10:40 RECESS TO VIEW EXHIBITS

10:40-11:00 "General Anesthesia in Dentistry"
FRANCIS M. GREM, Associate Professor of Anesthesia, Loyola University School of Dentistry, Chicago

11:00-11:20 "Hypothermia in Vascular Surgery"
PAUL W. SEARLES, Director of Anes-

thesia, St. Luke's Hospital, Chicago
MAX S. SADOVE, Head, Division of Anesthesiology, Research and Educational Hospitals, Chicago

11:20-11:40 "Local Analgesia in General Practice"
ERNST TRIER MORCH, Professor of Anesthesiology, University of Chicago School of Medicine; Director of Anesthesia, University of Chicago Hospitals and Clinics, Chicago

11:40-12:00 Business Meeting and Election of Section Officers

SECTION ON EYE, EAR, NOSE AND THROAT

CHAIRMAN ..... Philip R. McGrath, Peoria
SECRETARY ..... Fletcher Austin, Chicago
TUESDAY MORNING, May 17, 1955
The Assembly Room

9:00- 9:20 "The Treatment of Nasal Polyposis with Hydrocortisone"
WALTER E. OWEN, Peoria

9:20- 9:30 Discussion

9:30- 9:50 "Radiation Cataract"
DAVID SHOCH, Instructor in Ophthalmology, Northwestern University Medical School, Chicago

9:50-10:00 Discussion

10:00-10:20 "Carcinoma of the Larynx, Classification, and Results of Treatment"
JOHN R. LINDSAY and Associates, University of Chicago, The School of Medicine, Chicago

10:20-10:30 Discussion

10:30-11:00 "Non-Surgical Treatment of Concomitant Strabismus"
HERMANN M. BURIAN, Professor of Ophthalmology, University of Iowa Hospitals, University of Iowa College of Medicine, Iowa City

11:00-11:15 Discussion

11:15-11:30 Business Meeting and the Election of Section Officers

---

11:30 RECESS TO VIEW EXHIBITS

SECTION ON OBSTETRICS AND GYNECOLOGY

CHAIRMAN ... Howard L. Penning, Springfield
SECRETARY ..... Charles D. Krause, Chicago
TUESDAY MORNING, May 17, 1955
Old Chicago Room — No. 101

9:00- 9:20 "Occiput Posterior"
BEATRICE E. TUCKER, Chicago

9:20- 9:40 "Office Detection of Cancer"
VINCENT FREDA, Chicago

9:40-10:00 "Hysterosalpingography in Sterility"
KANE ZELLE, Springfield

10:00-10:30 RECESS TO VIEW EXHIBITS

10:30-10:50 "Ruptured Uterus"
GEORGE P. VLASIS, Chicago

10:50-11:10 "Obstetrical Anesthesia"
WENDEL R. FREEMAN, Champaign

11:10-11:40 "Immediate Care of the Post-Partum Patient"
WILLIAM BENBOW THOMPSON, Associate Professor of Obstetrics and Gynecology, Stanford University School of Medicine, San Francisco

11:45 BUSINESS MEETING and election of Section Officers.

SECTION ON CARDIOVASCULAR DISEASE

CHAIRMAN ..... V. Thomas Austin, Urbana
SECRETARY .... Chauncey C. Maher, Chicago
TUESDAY MORNING, May 17, 1955
The Gold Room — No. 114

9:00 "Supraventricular Tachycardia"
ROBERT W. ELLIOTT, Alton

9:20 "Ventricular Tachycardia"
EMMETT B. BAY, Professor, Department of Medicine, University of Chicago — The School of Medicine, Chicago

9:40 "Bundle Branch Block"
FORD K. HICK, Professor of Medicine, University of Illinois College of Medicine, Chicago

10:00- RECESS TO VIEW EXHIBITS
10:30

10:30 "Auricular Fibrillation"
ROBERT L. GRISSOM, Professor of Medicine, Assistant Chairman, Department of Medicine, University of Nebraska Medical School, Omaha

11:15 "Auriculo-Ventricular Block"
STANLEY L. LEVIN, Danville

11:35 QUESTION AND ANSWER PERIOD
Drs. Elliott, Bay, Hick, Grissom and Levin
BUSINESS MEETING — and Election of Section Officers

PHYSICIANS' ASSOCIATION of the DEPARTMENT OF PUBLIC WELFARE

TUESDAY MORNING, May 17, 1955
Ruby Room — No. 113

General Assembly

The Ballroom

TUESDAY AFTERNOON, May 17, 1955

Presiding ..... Ernest F. Kreutzer, Joliet
Assisting ..... Charles D. Krause, Chicago

1:30- 1:40 OPENING OF THE GENERAL ASSEMBLY
Arkell M. Vaughn, President, Illinois State Medical Society, Chicago

1:40- 2:00 "The Dangers of Delay"
WILLIAM B. THOMPSON, Associate Professor of Obstetrics and Gynecology, Stanford University School of Medicine, San Francisco, California

2:00- 2:20 "Safety in Modern Anaesthetic Practice"
JOHN GILLIES, Director, Department of Anesthesia, Royal Infirmary, Edinburgh, Scotland

2:20- 2:40 "Tumors of the Thyroid"
GEORGE CRILE, Jr., Chairman, Department of Surgery, Cleveland Clinic, Cleveland, Ohio

2:40- 3:10 RECESS TO VIEW EXHIBITS

Presiding ..... Philip R. McGrath, Peoria
Assisting ..... Chauncey C. Maher, Chicago

3:10- 3:30 "The Value of Routine Radiographic Examinations in the Diagnosis of Cardiac Anomalies and Diseases"
WENDELL G. SCOTT, Associate Professor of Clinical Radiology, Washington University School of Medicine, St. Louis, Missouri

3:30- 3:50 "Recent Advances in Drug Therapy"
ROBERT GRISSON, Professor of Medicine, Assistant Chairman, Department of Medicine, University of Nebraska College of Medicine, Omaha, Nebraska

3:50- 4:10 "Vascular Changes in the Eye in Hypertension and Other Pathologic Conditions"
HERMAN M. BURIAN, Professor of Ophthalmology, State University of Iowa College of Medicine, Iowa City, Iowa

SECTION ON RADIOLOGY

CHAIRMAN ..... E. Kenneth Lewis, Chicago
SECRETARY ..... Fred H. Decker, Peoria

TUESDAY AFTERNOON, May 17, 1955
The Crystal Room

3:30 p.m.

The guest moderator for the film reading session of the Section on Radiology will be WENDELL G. SCOTT, Associate Professor of Clinical Radiology, Washington University School of Medicine. St. Louis.

Following the scientific portion of the program, a business meeting and the election of Section Officers will be held.

Scientific Programs Scheduled for the Second Day of the Annual Meeting

Wednesday, May 18, 1955

SECTION ON EYE, EAR, NOSE AND THROAT

CHAIRMAN ..... Philip R. McGrath, Peoria
SECRETARY ..... Fletcher Austin, Chicago

WEDNESDAY MORNING, May 18, 1955
The Assembly Room

9:00- 9:20 "The Complications of Round Pupil Cataract Surgery"
EDWARD C. ALBERS, Christie Clinic, Champaign

9:20- 9:30 Discussion

9:30-11:30 SYMPOSIUM ON MAXILLOFACIAL INJURIES

9:30- 9:50 "Nasal Fractures"
IRA J. TRESLEY, Associate in Otolaryngology, Northwestern University Medical School, Chicago

9:50-10:10 "The Treatment of Fractures of the Mandible"
ORION H. STUTEVILLE, D.D.S., M.D., Professor of Maxillofacial and Oral Surgery, Northwestern University Dental School, Chicago

10:10-10:20 Discussion

10:20-10:50 "Fractures of the Middle Third of the Face"
G. KENNETH LEWIS, Clinical Associate Professor of Otolaryngology, University of Illinois College of Medicine, Chicago

10:50-11:10 "Anaesthesia for Maxillofacial Injuries"
MAX SADOVE and Associates, Professor of Surgery (Anaesthesia), University of Illinois College of Medicine, Chicago
11:10-11:30 Discussion

11:30 RECESS TO VIEW EXHIBITS

SECTION ON PATHOLOGY

CHAIRMAN . Benjamin Markowitz, Bloomington
SECRETARY ..... Franklin J. Moore, Chicago
WEDNESDAY MORNING, May 18, 1955
The Emerald Room — No. 104

9:00-10:00 Presentation of Case Reports and Current Research Projects by Pathology Residents
"Atypical Endometrial Changes Associated with the Presence of Chorionic Tissue in the Uterus or in Ectopic Sites"
R. PILDES AND J. WHEELER, Mt. Sinai Hospital, Chicago
"Chronic Lymphocytic Leukemia Associated with Hypergammaglobulinemia"
F. BUFFA, Mt. Sinai Hospital, Chicago
"Acute Liver Necrosis Following Use of Chloramphenicol"
A. SCHNEIDER, Research and Educational Hospitals, University of Illinois, Chicago
"Postpartum Candida Infection"
J. WHITAKER, Research and Educational Hospitals, University of Illinois, Chicago
Discussion of papers

10:15-10:50 "Clinical Chemical Significance of Ionography"
H. J. McDONALD, D.Sc., Professor and Chairman, Department of Biochemistry, Stritch School of Medicine, Loyola University, Chicago
Discussion

11:00-11:20 "Differential Diagnosis of Medical and Surgical Jaundice"
HANS POPPER, Pathologist, Cook County Hospital, Director of Hektoen Institute, Chicago
Discussion

11:30-11:50 "Recent Advances in Exfoliative Cytology"
E. A. McGREW, Assistant Professor of Pathology, University of Illinois College of Medicine, Chicago
Discussion

12:00 LUNCHEON and Annual Business Meeting — ELECTION OF SECTION OFFICERS
Business meeting of Illinois Society of Pathologists
Luncheon will be held in the same room — No. 104

Illinois Chapter
AMERICAN COLLEGE OF CHEST PHYSICIANS

WEDNESDAY MORNING, May 18, 1955
The Gold Room — No. 114
First Floor

PANEL DISCUSSIONS
9:15-12:00 noon.

1. HOME CARE OR INSTITUTIONAL CARE OF PULMONARY TUBERCULOSIS
ABEL FROMAN, Consultant in Tuberculosis, Manteno State Hospital, Manteno
ROBERT LEVITT, Assistant Professor, Department of Medicine, University of Illinois College of Medicine, Chicago
M. R. LICHTENSTEIN, Medical Director, Municipal Tuberculosis Sanitarium, Chicago

---

2. RECENT EXPERIENCES IN DIAGNOSIS AND TREATMENT OF CARDIOVASCULAR DISEASE
Moderator: BENJAMIN M. GASUL, Director, Pediatric Cardio-Physiology Department, Cook County Children's Hospital, Chicago
ROBERT F. DILLON, Associate-Attending Physician, Cook County Children's Hospital, Chicago
EGBERT H. FELL, Attending Surgeon, Cook County Children's Hospital, Chicago
CARL J. MARIENFELD, Associate-Attending Physician, Pediatric Cardiophysiology Department, Cook County Children's Hospital, Chicago

12:00 Luncheon and business meeting
OFFICERS:
Clifton Hall, President ..... Springfield
Albert H. Andrews, Jr., Vice-President and Acting Secretary ..... Chicago
Kenneth C. Johnston, Program Chairman .. .. Chicago
The LUNCHEON will be served in the same room — The Gold Room, No. 114

LUNCHEON
Illinois Chapter
AMERICAN COLLEGE OF CHEST PHYSICIANS
Wednesday noon, May 18
The Gold Room — No. 114
First Floor

SECTION ON PEDIATRICS

CHAIRMAN .... Ralph H. Kunstadter, Chicago
SECRETARY ..... J. Keller Mack, Springfield
THE SECTION ON PREVENTIVE MEDICINE & PUBLIC HEALTH has been invited to participate in this combined meeting.
WEDNESDAY MORNING, May 18, 1955

Louis XVI Room

9:00- 9:20 "The Diagnosis and Management of Rheumatic Fever in Children"
JOSEPH CHRISTIAN, Associate Professor in Pediatrics, Stritch School of Medicine of Loyola University, Alternate Attending Physician, LaRabida Sanatorium, Chicago

9:20- 9:40 "Malignancies in Childhood"
ROBERT EASTON, Methodist Hospital, and St. Francis Hospital, Peoria

9:40-10:00 "Retrolental Fibroplasia"
UDELL THIMSEN, Christian Welfare Hospital, East St. Louis

10:00-10:30 RECESS TO VIEW EXHIBITS

10:30-11:30 Panel on IMMUNITY AND ANTIBIOTICS

"Natural and Acquired Immunity"
CLIFFORD GRULEE, Jr., Associate Professor of Pediatrics and Assistant Dean, Tulane University, Louisiana School of Medicine, New Orleans.

"Artificial Immunity"
WINSTON B. TUCKER, Director of Public Health, City of Evanston

"Antibiotics as Related to Immunity"
MARK LEPPER, Associate Professor of Medicine, University of Illinois College of Medicine, Chicago

11:30 BUSINESS MEETING and the Election of Section Officers

LUNCHEON
Illinois Chapter — AMERICAN ACADEMY OF PEDIATRICS
WEDNESDAY NOON, May 18, 1955
Louis XVI Room

SECTION ON SURGERY

CHAIRMAN .... Howard P. Sloan, Bloomington
SECRETARY .... Cornelius M. Annan, Chicago

WEDNESDAY MORNING, May 18, 1955
The Old Chicago Room — No. 101

9:00- 9:15 "Common Urologic Problems in Children"
I. KEITH NEECE, Decatur

9:15- 9:30 "Pitfalls in the Management of Colles' Fracture"
JUSTIN C. McNUTT, Bloomington

9:30- 9:45 "Breast Lumps and Their Treatment"
LOUIS P. RIVER, Clinical Professor of Surgery, Stritch School of Medicine of Loyola University, Chicago

9:45-10:00 "The Use of Blood and Plasma in the Surgical Patient"
J. GARROTT ALLEN, Professor of Surgery, University of Chicago, The School of Medicine, Chicago

10:00-10:30 RECESS TO VIEW EXHIBITS

10:30 PANEL — GASTRO INTESTINAL BLEEDING
Moderator — Howard P. Sloan, Bloomington

10:30-10:40 "Prevention and Treatment of Massive Esophogeal Bleeding"
JOHN T. REYNOLDS, Clinical Professor, Department of Surgery, University of Chicago, The School of Medicine, Chicago

10:40-10:50 "Present Day Management of Bleeding Lesions of the Stomach and Duodenum"
ROBERT E. BOWEN, Springfield

10:50-11:00 "Bleeding from the Bowel"
J. C. THOMAS ROGERS, Carle Hospital Clinic, Urbana

11:00-11:10 "Physiological Consequences of Gastrointestinal Bleeding"
HAROLD LAUFMAN, Associate Professor, Department of Surgery, Northwestern University Medical School, Chicago

PANEL DISCUSSION

11:45 BUSINESS MEETING and the election of Section Officers

LUNCHEON
SECTION ON SURGERY
WEDNESDAY NOON, May 18, 1955
The Old Chicago Room — No. 101

General Assembly

The Ballroom
WEDNESDAY AFTERNOON, May 18, 1955
Presiding ..... Howard P. Sloan, Bloomington
Assisting ..... Cornelius M. Annan, Chicago

1:30- 1:50 THE PRESIDENT'S ADDRESS — ARKELL M. VAUGHN, President, The Illinois State Medical Society, Chicago

---

1:50- 2:20 THE ORATION IN SURGERY — "The Present Day Concepts in the Treatment of Venous Thrombosis"
ALTON J. OCHSNER, William Henderson Professor of Surgery, Chairman of the Department of Surgery, Tulane University — Louisiana School of Medicine, New Orleans

---

2:20- 2:50 THE ORATION IN MEDICINE — "Virus Problems in Medicine"
THOMAS FRANCIS, Jr., Professor and Chairman of Epidemiology, Virus Laboratory, University of Michigan School of Public Health, Ann Arbor, Michigan

2:50- 3:15 RECESS TO VIEW EXHIBITS
Presiding ..... Ralph H. Kunstadter, Chicago
Assisting ..... Herbert Ratner, Oak Park

3:15- 4:30 PANEL ON POLIOMYELITIS
Moderator: Julius H. Hess, Chicago

"Poliomyelitis Vaccine" — THOMAS FRANCIS, Jr., Ann Arbor, Michigan

"Status of Irradiated Poliomyelitis Vaccine"
HOWARD J. SHAUGHNESSY, Director, Division of Laboratories, Illinois Department of Public Health and
ALBERT M. WOLF, Director, Michael Reese Research Foundation, Chicago

"The Practicing Physician's Role in the Control of Poliomyelitis"
LEONARD M. SCHUMAN, Associate Professor of Public Health, University of Minnesota Medical School, Minneapolis

"Practical Aspects of Diagnosis and Care of Poliomyelitis"
CLIFFORD GRULEE, Jr., Assistant Dean, Pediatric Department, Tulane University — Louisiana School of Medicine, New Orleans

Scientific Programs Scheduled for the Third Day of the Annual Meeting

Thursday, May 19, 1955
SECTION ON ALLERGY

CHAIRMAN ..... Max Samter, Chicago
SECRETARY ..... Ellis Canterbury, Peoria

THURSDAY MORNING, May 19, 1955
The Gold Room — No. 114

9:00 "The Symptomatic Therapy of Bronchial Asthma"

A PANEL DISCUSSION — Milton M. Mosko, Moderator

"The Routine of Bronchial Asthma Control"
LEON UNGER, Associate Professor of Medicine, Northwestern University Medical School, Chicago

"Positive Pressure Breathing, Cough Stimulation and Oxygen Therapy"
GEORGE A. SAXTON, Jr., Director, Respiratory Center, University of Illinois College of Medicine, Chicago

"Inhalation Therapy of Bronchial Asthma"
MILTON M. MOSKO, Clinical Associate Professor of Medicine, University of Illinois College of Medicine, Chicago

---

10:00 "Breathing Exercises" — A Demonstration
AUDREY EVANS DeRANGO, A.B., R.P.T., Staff Physical Therapist, Department of Physical Medicine and Rehabilitation, University of Illinois College of Medicine, Chicago

10:30-11:00 RECESS TO VIEW EXHIBITS

11:00 "Reactions to Drugs"
A SYMPOSIUM — Adolph Rostenberg, Jr., Moderator
Participants:
LEONARD H. HARRIS, Peoria
NORMAN B. ROBERG, Associate Professor of Medicine, University of Illinois College of Medicine, Chicago
ADOLPH ROSTENBERG, Jr., Professor of Dermatology, University of Illinois College of Medicine, Chicago
PAUL L. WERMER, Secretary, Committee on Research, and Assistant Secretary, Council on Pharmacy and Chemistry of the American Medical Association, Chicago

LUNCHEON
SECTION ON ALLERGY
THURSDAY NOON, May 19, 1955
The Emerald Room — No. 104

SECTION ON MEDICINE

CHAIRMAN .... George Mason Parker, Peoria
SECRETARY ..... Jacques M. Smith, Chicago

THURSDAY MORNING, May 19, 1955
The Assembly Room

9:00 PANEL ON RENAL FAILURE
DAVID P. EARLE, Chicago — Moderator
JAMES A. SCHOENBERGER, Instructor in Medicine, University of Illinois College of Medicine, Chicago
J. KENNETH SOKOL, Wesley Memorial Hospital, Chicago
DAVID P. EARLE, Chicago

10:00 RECESS TO VIEW EXHIBITS

10:30 "Uncommon Sites of Herpes Zoster"
F. GARM NORBURY, The Norbury Sanatorium, Jacksonville

10:50 "Cortisone Therapy of Acute Thyroiditis"
ROBERT M. HOYNE, Urbana

11:10 Title to be announced
STEVEN O. SCHWARTZ, Professor of Hematology, Chicago Medical School, Chicago

11:30 BUSINESS MEETING and election of Section Officers

SECTION ON PREVENTIVE MEDICINE AND PUBLIC HEALTH

CHAIRMAN ..... R. F. Sondag, Murphysboro
SECRETARY ..... Herbert Ratner, Oak Park

THE SECTION ON PEDIATRICS has been

invited to participate in this combined meeting.

THURSDAY MORNING, May 19, 1955
Louis XVI Room

9:00 PANEL ON SCHOOL HEALTH AND THE FAMILY PHYSICIAN
Chairman: L. L. Fatherree, Joliet
George L. Drennan, Jacksonville
James Gillespie, Urbana
Edward M. Thompson, Clinton

10:20 Intermission

10:30 "The Extent and Depth of the Retrolental Fibroplasia Problem"
ARLINGTON KRAUSE, Associate Professor of Surgery (Ophthalmology) University of Chicago School of Medicine, Chicago

11:00 "The Recognition of Streptococcal Infections in the Prevention of Rheumatic Fever and Acute Glomerular Nephritis"
ALAN C. SIEGEL. Winnetka

11:30 "The Public Health Aspects of Breast-Feeding"
HERBERT RATNER, Associate Clinical Professor of Preventive Medicine and Public Health, Stritch School of Medicine, Loyola University; Health Commissioner, Oak Park

12:00 BUSINESS MEETING and the election of Section Officers

LUNCHEON

SECTION ON PREVENTIVE MEDICINE AND PUBLIC HEALTH
with the
ILLINOIS ASSOCIATION OF MEDICAL HEALTH OFFICERS
Thursday Noon, May 19, 1955
Louis XVI Room

SECTION ON DERMATOLOGY

CHAIRMAN ..... Hans M. Buley, Champaign
SECRETARY ..... Malcolm Spencer, Danville

THURSDAY MORNING, May 19, 1955
The Old Chicago Room — No. 101

9:30 Chairman's Address: "The Dermatologist's Role in Medicine"
HANS M. BULEY, Christie Clinic, Champaign

9:45 "Skin Eruptions Caused by or Aggravated by Sunlight"
OTTO C. STEGMAIER, Jr., Moline
Discussant: Ralph W. E. Wise, Springfield

10:05 "The Role of the Tranquilizing Drugs (Thorazine and Rauwolfia Derivatives) in Dermatology"
THEODORE CORNBLEET, Clinical Professor of Dermatology, University of Illinois College of Medicine, Chicago
SIDENY BARSKY, Chicago
Discussant: Matthew J. Brunner, Chicago

10:30 RECESS TO VIEW EXHIBITS

11:00 PANEL — "The Management of the Superficial Fungous Infections"
MODERATOR: Francis E. Senear, Professor Emeritus, Department of Dermatology, University of Illinois College of Medicine, Chicago

The members of the PANEL will consist of the Chairmen of the Departments of Dermatology from all the medical schools in Chicago.

Kodachromes of exemplary cases will be presented for discussion. Management will be stressed.

FRANCIS E. SENEAR, Moderator, University of Illinois College of Medicine
STEPHEN ROTHMAN, University of Chicago School of Medicine
HERBERT RATTNER, Northwestern University Medical School
CLEVELAND J. WHITE, Stritch School of Medicine, Loyola University
DAVID M. COHEN, Chicago Medical School

12:00 BUSINESS MEETING and election of Section Officers

LUNCHEON
SECTION ON DERMATOLOGY
Thursday Noon, May 19, 1955
Room 101

General Assembly

The Ballroom
THURSDAY AFTERNOON, May 19, 1955

Presiding ..... George Mason Parker, Peoria
Assisting ..... Malcolm Spencer, Danville

1:30- 1:50 "Allergy and the Specialties"
SAMUEL M. FEINBERG, Professor of Medicine, Northwestern University Medical School, Chicago

---

1:50- 2:10 "The Dermatologist's Role in the Treatment of Skin Cancer"
HENRY E. MICHELSON, Professor of Dermatology, University of Minnesota Medical School, Minneapolis

---

2:10- 2:30 "Interpretation of the Routine Blood Count"
KEITH TRUEMNER, Rockford Memorial Hospital, Rockford

2:30- 3:00 RECESS TO VIEW EXHIBITS

Presiding ..... Max Samter, Chicago

Assisting ..... Ellis Canterbury, Peoria

3:00- 4:30 THE STUFFED-UP NOSE — Panel Discussion

MODERATOR: MAX SAMTER, Associate Professor of Medicine, University of Illinois College of Medicine, Chicago

A. L. AARONSON, Assistant Professor of Medicine, (Allergy) The Chicago Medical School, Chicago

MARC HOLLENDER, Associate Professor of Psychiatry, University of Illinois College of Medicine, Chicago

FRANCIS L. LEDERER, Professor of Otolaryngology and Chairman of the Department, University of Illinois College of Medicine, Chicago

The Illinois Association of Blood Banks

FIFTH ANNUAL MEETING
Friday Afternoon, May 20, 1955
Louis XVI Room

2:00- 2:15 "Pediatric Considerations in a Transfusion Service"

JOSEPH D. BOGGS, Pathologist and Director of Blood Bank, Children's Memorial Hospital, Chicago

(2:15- 2:20 — Discussion)

2:20- 2:35 "Exchange Transfusion — Technique and Practical Clinical and Laboratory Considerations"

ROBERT MENDELSOHN, Pediatric Department and Exchange Transfusion Service, Michael Reese Hospital, Chicago

(2:35- 2:40 — Discussion)

2:40- 2:55 "Development of the Clearing House Blood Program in the North Central District"

PAUL VAN PERNIS, Director, Northern Illinois Blood Bank, Rockford; Chairman, North Central District Clearing House.

(2:55- 3:00 — Discussion)

3:00- 3:15 "The Problem of Reporting Transfusion Reactions to the Blood Bank"

DONALD R. RUSS, Director of Blood Bank, Research and Education Hospitals, Chicago; Instructor in Pathology, University of Illinois College of Medicine, Chicago.

(3:15- 3:20 — Discussion)

3:20- 3:35 "Diagnosis of Hemolytic Transfusion Reactions"

FRANK TROBAUGH, Director of Blood Bank, Presbyterian Hospital, Chicago

(3:30- 3:40 — Discussion)

3:40- 3:55 "Donor Recruitment in Hospital and Private Blood Banks"

MISS MILDRED DeLONG, M.T., A.S.C.P., Chief Blood Bank Technician, Ravenswood Hospital, Chicago

(3:55- 4:00 — Discussion)

4:00- 5:00 ANNUAL BUSINESS MEETING AND ELECTION OF OFFICERS

Social Affairs — Luncheons — Dinners

TUESDAY, May 17, 1955

PUBLIC RELATIONS DINNER — The Crystal Room

HOSPITALITY HOUR — The Bal Tabarin — Sixth Floor at 9:30 p.m.

WEDNESDAY, May 18, 1955

Women Physicians' Breakfast at 8:00 a.m. in The Ruby Room — No. 113

Luncheon for the Section on Surgery — The Old Chicago Room — No. 101

Luncheon for the Section on Pathology — The Emerald Room — No. 104

Luncheon for the Illinois Chapter, American Academy of Pediatrics — Louis XVI Room

Luncheon for the Illinois Chapter, American College of Preventive Medicine, The Jade Room — No. 103

Speaker: Lt. Col. Claude M. Eberhart, Officer, Preventive Medicine, Fifth Army Headquarters, Chicago

"Military Preventive Medicine"

Business session will follow the luncheon and program

The Assembly Room

THE FIFTY YEAR CLUB LUNCHEON —

THE ANNUAL DINNER — The Ballroom

The speaker this year will be CLARENCE MANION, Former Dean of the Law School of Notre Dame University, South Bend, Indiana

The dinner will honor the retiring President — ARKELL M. VAUGHN of Chicago. The immediate Past President, Willis I. Lewis of Herrin will preside

THURSDAY, May 19, 1955

Phi Chi Medical Fraternity Luncheon — Room 106

Luncheon for the Section on Dermatology — The Jade Room — No. 103

Luncheon for the Section on Allergy — The Emerald Room — No. 104

Luncheon for the Section on Preventive Medicine and Public Health with the Illinois Association of Medical Health Officers — The Louis XVI Room

THE LOYOLA ALUMNI DINNER — The Crystal Room

Phi Beta Pi Smoker — Will be held at Abbott Hall, 710 North Lake Shore Drive, Chicago — to show the alumni the fraternity's new quarters. 7:30 p.m. — Abbott Hall — 8th Floor Lounge. Transportation will be provided for those desiring it from the hotel to the Smoker. Further information will be published later.

Technical Exhibitors

	Booth
Abbott Laboratories, North Chicago	110
A. S. Aloe Company, St. Louis, Missouri	2
American Hospital Supply Corp., Evanston	98
Audio Digest Foundation, Glendale, Calif.	33
Baby Development Clinic, Chicago	3
Baker Laboratories, Inc., Cleveland, Ohio	102
Baxter Laboratories, Evanston	98
Beech-Nut Packing Co., New York, N. Y.	100
Blue Cross-Blue Shield, Chicago	38, 39
Cameron Surgical Specialty Company, Chicago	56
Chicago Medical Book Company, Chicago	36
Chicago Pharmacal Company, Chicago	99
Ciba Pharmaceutical Products, Inc., Summit, N. J.	9
The Coca Cola Company, Atlanta, Georgia	14
Crib Diaper Service, Chicago	48
Daniels Surgical & Medical Supplies, Chicago	15, 16, 17
Doho Chemical Corporation, New York, N. Y.	25
Eisele and Company, Nashville, Tenn.	8
Electro Medical Equipment Co., Chicago	18
Eli Lilly & Company, Indianapolis, Ind.	95
Encyclopedia Americana, Grand Rapids, Michigan	55
Encyclopaedia Britannica, Chicago	58, 59
Executone Company, Chicago	50
General Foods Corporation, White Plains, New York	1
H. J. Heinz Company, Pittsburgh, Penna.	64
Jackson-Mitchell Pharmaceuticals, Inc., Culver City, Calif.	24
The "Junket" Brand Foods, Little Falls, New York	7
Julius Schmid, Inc., New York, N. Y.	53
Lederle Laboratories Division, American Cyanamid Company, Pearl River, New York	35
J. B. Lippincott Company, Philadelphia, Penna.	62
P. Lorillard Co., New York, N. Y.	11
M & R Dietetic Laboratories, Columbus, Ohio	61
Mead Johnson & Company, Evansville, Ind.	111
Medco Products Co., Tulsa, Oklahoma	29
Medical Aids, Inc., Chicago	12
Medical Protective Company, Fort Wayne, Indiana	106
Miles Reproducer Co., New York, N. Y.	13
Miller Surgical Company, Chicago	112
V. Mueller & Company, Chicago	101
National Drug Company, Philadelphia, Penna.	26
Nepera Chemical Co., Inc., Yonkers, N. Y.	105
Northern Illinois Medical Service, Inc., Rockford	34
NRD Instrument Co., St. Louis, Missouri	20
Parke, Davis & Co., Detroit, Michigan	94
Parker Aleshire & Co., Chicago	5
Charles Pfizer & Co., Brooklyn, N. Y.	60
Professional Management, Bloomington	21
The Purdue Frederick Co., New York, N. Y.	109
R. J. Reynolds Tobacco Company, Winston-Salem, N. C.	32
A. H. Robins Company, Richmond, Virginia	108
J. B. Roerig & Company, Chicago	28
Sanborn Company, Cambridge, Mass.	4
Sandoz, Pharmaceuticals, East Hanover, New Jersey	27
W. B. Saunders Company, Philadelphia, Penna.	104
Schering Corporation, Bloomfield, N. J.	57
Schick X-Ray Company, Inc., Chicago	22
G. D. Searle & Co., Chicago	65
Sharp & Dohme, Philadelphia, Penna.	96
Sherman Laboratories, Detroit, Michigan	107
Smith, Kline & French Laboratories, Philadelphia, Penna.	6
E. R. Squibb & Sons, New York, N. Y.	97
Universal Products Corporation, Norristown, Penna.	Table space
Upjohn Company, Kalamazoo, Michigan	103
United States Tobacco Co.	52
Varick Pharmacal Company, New York, N. Y.	51
Vitamin Products Company, Milwaukee, Wis.	23
Winthrop-Stearns, Inc., New York, N. Y.	10
The Zemmer Company, Inc., Pittsburgh, Penna.	63

Here's What Our Exhibitors Will Show You

ABBOTT LABORATORIES
Booth 110

A. S. ALOE COMPANY
Booth 2

Visit Booth No. 2. The A. S. Aloe Company will have on display a full line of physicians' and surgeons' supplies. Featured will be New Aloe Steeline Treatment Room Furniture and the Aloesonic "Ultra sound therapy unit".

AMERICAN HOSPITAL SUPPLY CORPORATION
Scientific Products Division
Booth 98

Scientific Products Division, American Hospital Supply Corporation, will exhibit the complete line of Baxter intravenous solutions including new Travert solutions and their contribution to carbohydrate metabolism. Also featured will be new Plexitron sets for parenteral therapy and new blood pumps for rapid blood transfusions.

AUDIO DIGEST FOUNDATION
Booth 33

Audio-Digest Foundation — a non-profit subsidiary of the California Medical Association — gives a busy physician an effortless tour through the best of current medical literature each week. This medical "newscast" — compiled and reviewed by a professional Board of Editors — may be heard in the physician's automobile, home, or office.

The Foundation — whose profits are distributed among the nation's medical schools — also offers tape-recorded medical lectures by nationally recognized authorities.

BABY DEVELOPMENT CLINIC
Maternity Counselling Service
Booth 3

Maternity Counselling Service offers:

(1) Products and literature helpful in teaching expectant mothers (and fathers) physician and emotional aspects of parent-child relationship arising out of daily care.

(2) Aids for parents to understanding and providing emotional security for children through school ages.

BAKER LABORATORIES, INC.
Booth 102

You are invited to visit our booth where Baker's Modified Milk and Varamel, two successful products for infant feeding, are on display.

Baker representatives will be glad to discuss the practical application of Grade A milk, adjusted fat composition, zero curd tension, synthetic vitamins and other important factors which help to eliminate many of the problems in modern infant feeding.

BAXTER LABORATORIES, INC.
Booth 98

For summary of exhibit, see "American Hospital Supply Corp."

BEECH-NUT PACKING COMPANY
Booth 100

Have you used the BEECH-NUT STRAINED AND JUNIOR FOODS for your GERIATRIC as well as your PEDIATRIC patients?

Beech-Nut Nutritionists will be present to answer any questions you may have regarding the products available for special feedings.

BLUE CROSS-BLUE SHIELD
Booths 38 & 39

CAMERON SURGICAL SPECIALTY COMPANY
Booth 56

See the Cameron New Cauteradiodyne and Cauterodynes for both office and hospital use incorporating Cauterization, Coagulation, Fulguration, Desiccation, Dehydration and orificial Ultraviolet radiation;

also new Biopsy Cutagulator;

Electro-Diagnostic Lamp and Instrument Outfits;

the improved Omniangle Gastroscope;

the Boros Flexible Esophagoscope;

Coagulair and Dualite Sigmoidoscopes;

Tele-Vaginalite;

Mirrolite and other Headlites, Retractors and many other Instruments for general and special Diagnosis, Treatment and Surgery.

CHICAGO MEDICAL BOOK COMPANY
Booth 36

CHICAGO PHARMACAL COMPANY
Booth 99

Chicago Pharmacal features the following Chimedic products of its quality line: URISED, nationally-known and clinically proven tablet for the treatment of cystitis, which performs both a thorough sedation and antisepsis; TOLYPHY, the improved spasmolysis formula, in tablet and liquid form; CEVICETYL, time-tried combination of aspirin and ascorbic acid in tablet form, for the safe, effective treatment of the common cold, plus a complete line of injectables.

CIBA PHARMACEUTICAL PRODUCTS, INC.
Booth 9

THE COCA-COLA COMPANY
Booth 14

Ice-cold Coca-Cola served through the courtesy and co-operation of the Coca-Cola Bottling Company of Chicago, Inc., and The Coca-Cola Company.

CRIB DIAPER SERVICE
Booth 48

While you're browsing through the exhibits, why not stop at the Crib Diaper Service Booth. Find out for yourself what Crib does to help the mother of a new born baby. Our representative will be glad to discuss any phase of the diaper industry with you.

While at the booth, arrangements can be made for urine specimen bottles and appointment envelopes. This is a free service to all doctors in the Chicagoland area.

DANIELS SURGICAL & MEDICAL SUPPLIES
Booths 15, 16, 17

Daniels — on the entire north end of the exhibition hall — will feature this year "A DOCTOR'S MODEL OFFICE" featuring the newest and most modern type of medical furniture and equipment. Such lines as HAMILTON's New Medical Furniture, RITTER's "Time Saving" and "Energy Saving," electrically operated Examining Table. BURDICK's E.K.G., New Ultra-Sonic and Micro Wave Units, Infra Red and Ultra Violet Lamps and its D-54 Portable Diathermy — the Sensational New EXAMINING LAMP "LUXO," "The Lamp of the Century."

AMERICAN AND CASTLE Autoclaves and Sterilizers, ROYAL METAL Reception Room and, JASPER Consultation Room Furniture. The newest in Proctoscopes, Otoscopes, Headlamps and WELCH ALLYN's latest Diagnostic Equipment, its line of SKLAR instruments and top quality physicians' medical bags.

DOHO CHEMICAL CORPORATION
Booth 25

Doho Chemical Corporation exhibits AURALGAN, the time-honored decongestant and pain reliever in Otitis Media, also for removal of Cerumen; RHINALGAN, the equally safe nasal decongestant for infants and the aged; NEW OTOSMOSAN, the fungicidal and bactericidal ear medication.

Mallon Chemical Corporation, a subsidiary, features RECTALGAN, the liquid topical anesthesia for relief of pain and discomfiture in hemorrhoids, pruritus and perineal suturing.

EISELE AND COMPANY
Booth 8

Eisele and Company will display their regular line of clinical thermometers, hypodermic syringes, both the regular and interchangeable type, hypodermic needles, Eco bandages, and specialty glassware.

ELECTRO-MEDICAL EQUIPMENT COMPANY
Booth 18

ELI LILLY AND COMPANY
Booth 95

You are cordially invited to visit the Lilly exhibit located in space number 95. The display will contain information on recent therapeutic developments. Lilly sales people will be in attendance. They welcome your questions about Lilly products.

ENCYCLOPEDIA AMERICANA
Booth 55

ENCYCLOPAEDIA BRITANNICA
Booths 58 & 59

EXECUTONE COMPANY
Booth 50

Communications and Sound Systems for hospitals, clinics and nursing homes! Confidential, fully private type administrative intercom systems for DOCTORS' SUITES, MEDICAL CLINICS, NURSING HOMES and HOSPITALS. Direct voice Doctor Paging Systems — Music Distribution Systems — and the new Multi-Visual Nurse Call System to provide voice communications between nurse and her patient.

GENERAL FOODS CORPORATION
Booth 1

H. J. HEINZ COMPANY
Booth 64

Heinz Strained Meats — first in glass jars — have been readily accepted by the medical profession and mothers alike.

Now, Junior Meats have been added and the Heinz line of baby foods, including the other strained and junior items, orange juice and cereals, totals over 60 varieties. Babies, young children and those elderly folks requiring soft diets may have a wide selection from the very nourishing foods.

See our booth and the literature which is available for physicians and patients.

JACKSON-MITCHELL PHARMACEUTICALS, Inc.
Booth 24

On display Meyenberg Evaporated Goat Milk, the original prescription, quality goat milk, and HI-PRO, the high protein, low fat, modified, powdered cow's milk. Delicious, ice cold goat milk is

being served. Jackson-Mitchell representatives have some new literature on the use of Goat Milk and HI-PRO.

"JUNKET" BRAND FOODS
Booth 7

Learn the essential facts concerning the enzyme rennet and the value of rennet desserts in the diets of your patients.

The importance of this whole milk dessert for children and adults who need the nutritive benefits of milk in easily digested form will be explained.

Literature on the enzyme rennet and food value of rennet desserts will be offered. Recipes and information on the composition of "JUNKET" Rennet Powder and "JUNKET" Rennet Tablets are available.

LEDERLE LABORATORIES DIVISION
American Cyanamid Company
Booth 35

You are cordially invited to visit our exhibit in Booth 35 where you will find our representative prepared to give you the latest information on LEDERLE products.

J. B. LIPPINCOTT COMPANY
Booth 62

P. LORILLARD COMPANY
Booth 11

M & R LABORATORIES
Booth 61

MEAD JOHNSON & COMPANY
Booth 111

Mead Johnson & Company invite you to see new displays of Liquid Lactum and Powdered Lactum, the infant formula products with balanced caloric distribution. Also featured in the Mead booth will be Liquid Sobee, a hypoallergenic (milk-free) soya formula; Natalins, the smaller prenatal vitamin-mineral capsules; Natalins-T, for the treatment of anemias of pregnancy plus protective nutritional support; and Sustagen, the complete food for tube or oral feeding.

MEDCO PRODUCTS COMPANY
Booth 29

THE MEDCOLATOR Stimulator, for the stimulation of innervated muscle or muscle groups ancillary to treatment by massage, is a low volt generator that will generate plenty of your interest. Electrical muscle stimulation is a valuable form of rehabilitation therapy.

Be sure to visit our booth for a personal demonstration.

MEDICAL AIDS, INC.
Booth 12

Medical Aids, Incorporated, will feature a complete line of pressure bandages, including the well known Dalzoflex and Primer Combination, recommended in the treatment of Varicose Ulcers, Phlebitis, etc.

The Nulast elastic crepe bandage, constructed of Viscolax Rubber Threads, Dalmas Elastic Strapping, which is waterproof, oil and grease resistant and Dalmaplast Plastic Adhesive Strapping.

THE MEDICAL PROTECTIVE COMPANY
Booth 106

An unparalleled record of successful malpractice protection since 1899 distinguishes The Medical Protective Company from all others.

Year in and year out 99.94 per cent of its policyholders have been completely covered under $2,500.00.

It's a sustained record that causes Medical Protective to be considered the doctor's most secure source of security.

MILES REPRODUCER COMPANY
Booth 13

Case histories, lectures and dictation may now be recorded at a 60-foot radius with Walkie-Recordall — an 8-pound, self-powered battery recorder-transcriber. It operates in or out of the closed briefcase, indoors or outdoors, while stationary, walking, riding or flying. The Voice-Activated "Self-Start-Stop" feature automatically starts and stops the recording from microphone or telephone, thus eliminating supervision and the recording of silent periods.

While facilities for transcribing are available, transcription may be eliminated due to the ease of handling identifiable, compact, indexed recordings without the delay of rewinding. Up to eight hours of permanent recordings may be accumulated at intervals on an "endless" belt costing 25 cents.

MILLER SURGICAL COMPANY
Booth 112

MILLER SURGICAL COMPANY, Chicago, will show the Miller Electro-scalpel. This unit cuts, desiccates, fulgurates, coagulates and is used for most delicate work up to light major surgery.

Accessories such as Snares, Smoke Ejectors, Flexible Electrodes, are also available. A complete line of Otoscopes, Ophthalmoscopes, Eyespud with Magnet, Transillumination Lamps, Headlights, Vaginal Speculum with Smoke Ejector, and stainless steel Proctoscopes, all sizes, with magnification, are also on display.

V. MUELLER & COMPANY

Booth 101

The V. Mueller & Company (Chicago) exhibit will include a comprehensive selection of fine instruments — both standard and special — for every field of modern surgery.

Mueller Ether-Vacuum Units will also be shown, including the latest explosion-proof models, featuring the Mueller Atomatic Lubrication System.

THE NATIONAL DRUG COMPANY

Booth 26

You are cordially invited to visit the booth of The National Drug Company. The featured product will be PARENZYME INTRAMUSCULAR Trypsin.

PARENZYME INTRAMUSCULAR Trypsin is a new, effective weapon against acute local inflammation. It restores local circulation with dramatic benefits in Phlebitis (thrombophlebitis and phlebothrombosis); Ocular Inflammation, (iritis, iridocyclitis and chorioretinitis); Traumatic Wounds; and Varicose and Diabetic Leg Ulcers.

PARENZYME INTRAMUSCULAR Trypsin is based on an entirely new concept of biological continuity . . . . in terms of clinical enzymology. In very small doses, it initiates physiologic mechisms — and dramatically restores circulation, expedites repair of tissue and prevents tissue necrosis.

NEPERA CHEMICAL COMPANY, Inc.

Booth 105

The Nepera exhibit features a new drug, Choledyl (choline theophyllinate), which represents a major advance in oral theophylline therapy. Whenever an oral xanthine is indicated, Choledyl assures higher theophylline blood levels, greater effectiveness, and superior patient tolerance.

Also featured — Biomydrin Nasal Spray for effective antibiotic activity, prolonged nasal decongestion, and antiallergic effect.

Biomydrin Otic, for antibacterial, antifungal, and antipruritic action in otitis externa and media.

Two other preparations will be exhibited: Mandelamine Hafgrams, a urinary antiseptic; and Neohetramine, an antihistaminic.

NORTHERN ILLINOIS MEDICAL SERVICE, Inc.

Booth 34

NRD INSTRUMENT COMPANY

Booth 20

The NRD Instrument Company's exhibit will consist of a display of all the latest instruments used in the hospitals and laboratories employing radioisotopes. Not only will the regular line of scalers, scintillation, counters, and Geiger counters be on display, but in addition our new completely automatic mediscanner will be shown and demonstrated.

Members of the parent company, Nuclear Consultants will also be present to explain their complete consulting service. By utilizing this service even small general hospitals may now undertake an isotope program with success.

PARKE, DAVIS & COMPANY

Booth 94

Medical service members of our staff will be in attendance at our exhibit for consultation and discussion of various products of particular interest to members of the Illinois State Medical Society.

Important specialties, such as Penicillin S-R, Benadryl, Ambodryl, Dilantin Suspension, Vitamins, Oxycel, Milontin, Amphedase, Thrombin Topical, etc., will be featured. You are cordially invited to visit our exhibit.

PARKER, ALESHIRE & COMPANY

Booth 5

Your membership in the Illinois State Medical Society entitles you to participate and take advantage of the SPECIAL SICKNESS AND ACCIDENT PLAN now in the 9TH YEAR of successful operation.

Please stop and visit with our representative in order that you may obtain information regarding this exceptional income protection which is a "MUST" for every complete insurance program.

PFIZER LABORATORIES

Booth 60

You are invited to visit the Pfizer booth. TERRAMYCIN INTRAMUSCULAR, CORTRIL, BONAMINE AND TYZINE will be the highlights this year of a star-studded cast including the complete line of TESTED and PROVED Terramycin dosage forms and the Steraject line of injectable Penicillin and Combiotic preparations.

PROFESSIONAL MANAGEMENT —

Booth 21

PROFESSIONAL MANAGEMENT — with over 22 years of specializing in the *Business Side of Medicine* invites you to stop at Booth 21 and meet Bert Cooper and Roger Peterson, resident partners in our Bloomington office.

Residents and Interns as well as physicians now in practice, are invited to consult with us.

Affiliated with Black & Skaggs Associates, Inc., of Battle Creek, Michigan.

THE PURDUE FREDERICK COMPANY

Booth 109

The Purdue Frederick Company of New York

welcomes you to their presentation of PRE-MENS for relief of entire complex syndrome of premenstrual tension; COLPOTAB, most effective antibiotic trichomonacidal vaginal insert tablet with fewest side effects; and CHLOROGIENE Duchettes, esthetically acceptable hygienic douche and adjunctive therapy in vaginal infections.

Representatives from our Medical Department will be happy to discuss with you technical and scientific aspects of our products and to provide you with recently published scientific reports and clinical trial supplies of these medicinals.

R. J. REYNOLDS TOBACCO COMPANY
Booth 32

Welcome to the R. J. Reynolds Tobacco Company Exhibit! You are cordially invited to receive a cigarette case (monogrammed with your initials) containing your choice of CAMEL, CAVALIER King Size, or WINSTON, the distinctive new king size, filter cigarette.

A. H. ROBINS COMPANY, Inc.
Booth 108

Physicians attending the meeting of the Illinois State Medical Society are extended a cordial invitation to visit the exhibit of the products of the A. H. Robins Company.

Experienced medical representatives will be in attendance to welcome you and answer inquiries relative to any of Robins' prescription specialties.

J. B. ROERIG AND COMPANY
Booth 28

Physicians and their friends are cordially invited to visit the ROERIG booth where there will be highlighted the Company's preparations, some of which Roerig has pioneered and established for a wide acceptance in the medical profession.

ROETINIC, the new One-A-Day capsule hematinic for all anemias amenable to oral therapy.

BONADOZIN, for the prevention of nausea and vomiting of pregnancy and post operatively.

ASF, Roerig's new anti-stress formula, and VITHYRO, for the vitalized thyroid and improved thyroid action.

Also available will be VITERRA, VITERRA THERAPEUTIC AMPULES, OBRON, OBRON HEMATINIC and HEPTUNA PLUS.

Samples and literature may be had on all products including adequate amounts for clinical trial.

SANBORN COMPANY
Booth 4

Featured at the Sanborn Company booth will be a continous demonstration of the new Sanborn Viso-Scope, a 5-inch cathode ray oscilloscope, especially designed for use with Sanborn Direct-writing electrocardiographs, such as the famous Viso-Cardiette — as well as with more elaborate recording systems used in the research laboratory.

The Viso-Cardiette itself will also be prominently displayed, as will the popular Sanborn Metabulator. In addition full data will be available on Sanborn 1, 2, and 4-channel direct-writing recording systems: the Twin-Beam photographic recorder for simultaneous phonocardiography: the Electromanometer, for physiologic pressure measurements: and other Sanborn equipment for cardiovascular diagnosis and research.

SANDOZ PHARMACEUTICALS
Booth 27

W. B. SAUNDERS COMPANY
Booth 104

Mr. Jennison will again be on hand displaying Saunders latest titles of interest to the practicing physician. Among them are: Cecil-Loeb: — 9th edition — Textbook of Medicine; Deutschberger: Fluoroscopy; Greenhill: — 11th edition — Obstetrics; Ochsner & DeBakey: Christopher's — 7th edition — Minor Surgery; and many others.

SCHERING CORPORATION
Booth 57

Members of the Illinois State Medical Society and their guests are cordially invited to visit the Schering exhibit where new therapeutic developments will be featured.

Schering representatives will be present to welcome you and to discuss with you these products of our manufacture.

SCHICK X-RAY COMPANY, Inc.
Booth 22

The Schick X-Ray Company, Inc., is the exclusive distributor for PROFEXRAY, and the members of the Illinois State Medical Society are cordially invited to stop at the Schick booth and visit with the representatives of the company.

JULIUS SCHMID, INC.
Booth 53

Julius Schmid, Inc., has prepared an interesting and informative exhibit on their products RAMSES Flexible Cushioned Diaphragm, RAMSES Jelly, XXXX "FOUREX" Skins in the control of re-infection in Trichomonas vaginalis, and its new product, VAGISEC, which embodies "Carlendacide" the new development of C. H. Davis, M.D., and C. G. Grand in the therapy of Trichomonas vaginalis infections.

G. D. SEARLE & COMPANY

Booth 65

You are cordially invited to visit the SEARLE booth where our representatives will be happy to answer any questions regarding Searle Products of research.

Featured will be Mictine, the new safe, non-mercurial oral diuretic; Vallestril, the new synthetic estrogen with extremely low incidence of side reactions; Banthine and Pro Banthine, the standards in anti-cholinergic therapy; and Dramamine, for the prevention and treatment of motion sickness and other nauseas.

SHERMAN LABORATORIES

Booth 107

PROTAMIDE

A sterile colloidal solution of denatured proteolytic enzyme. Published clinical studies have convincingly established Protamide's value in neuritis, herpes zoster and tabes dorsalis.

GERICAPS

A lipotropic formula containing choline and inositol, rutin and Vitamin C, A and B-Complex. A lipotropic with "plus" factors as an aid in diabetes, atherosclerosis and cirrhosis.

SMITH, KLINE & FRENCH LABORATORIES

Booth 6

At this meeting, "Thorazine" will be featured. "Thorazine" has an amazingly wide scope of clinical applications — and S.K.F. representatives will be ready with the latest information on whichever phase is of most interest to you.

With the oncoming summer season, we think that "Vasocort" — the anti-allergic nasal preparation containing hydrocortisone — will claim your attention.

We hope you will stop by at our Booth — our representatives will be glad to discuss these and other S.K.F. specialties with you.

E. R. SQUIBB & SONS

Division of Olin Mathieson Chemical Corporation

Booth 97

UNIVERSAL PRODUCTS CORPORATION

Table Space

You've often wished to have a light at the end of your finger. The new "Surgeon's Fingalyte" is just that. Bulb on finger tip, it penetrates into all cavities, gives perfect cold transillumination, and saves the physician's time.

Other features include a headlight (weighing only two ounces) and all of your diagnostic lighting needs contained in a small case.

Also the surgeon's "X-L-Lyte" with a record of over 80,000 in use. The new Amplifying Electronic Stethoscope will be exhibited.

THE UPJOHN COMPANY

Booth 103

THE UNITED STATES TOBACCO CO.

Booth 52

VARICK PHARMACAL COMPANY, Inc

Booth 51

VITAMIN PRODUCTS COMPANY

Booth 23

It is obvious that where nutritional deficiencies exist, their correction is essential to the complete recovery of the patient. It is also obvious that regardless of the form of other therapy that may be used, the correction of nutritional deficiencies is a basic and indispensable feature of treatment where it is required, and that only the practical experience of the physician can be the final guide in selecting nutritional factors.

WINTHROP-STEARNS, INC.

Booth 10

THE ZEMMER COMPANY, INC.

Booth 63

We cordially invite the members of the Illinois State Medical Society to visit our exhibit. Our representatives, Robert Ehlers and Milton Carrier will be in attendance to serve you.

1955 CONVENTION HIGHLIGHTS
WOMAN'S AUXILIARY
to the
ILLINOIS STATE MEDICAL SOCIETY

HOTEL SHERMAN, Chicago

TO: Wives of all Illinois Physicians:

The following program is for your pleasure and convenience.

Just the high lights are mentioned here. The names of the majority who are to participate will be in the May issue of the Illinois Medical Journal. We need all of you at our Convention; and you, as physicians' wives, need the information and stimulation which the varied program will give you.

Our Fashion-Luncheon will be held in the Sarah Siddon Walk of the Ambassador East Hotel; our President's Luncheon, in the Assembly Room at the Hotel Sherman, is designed to please those in attendance, and our Convention Program in itself, will inspire you to do your utmost for the vast program set forward by the American Medical Association.

Each item on the Wednesday program will be followed by audience participation. It is therefore impossible for us to say who will be on the program, because it depends on you and your activity.

You will make this Convention a success by your attendance.

Cordially,

MRS. DARRELL H. TRUMPE,
Convention Chairman

MRS. GEORGE PASTNACK, Convention Co-Chairman

WOMAN'S AUXILIARY PROGRAM

TUESDAY, May 17, 1955

8:30- 9:00 Registration on Mezzanine Floor

NOTE: State Board Members and Delegates who arrive on Monday, May 16, 1955, please register on that date.

DOORS to the opening session will close at 9:00 a.m.

8:30 a.m. County presidents and Councilors please report at the front of the Crystal Room on First Floor

9:00 a.m. Formal Opening of the Twenty-Seventh Annual Meeting of the Woman's Auxiliary to the Illinois State Medical Society Crystal Room — First Floor

Mrs. Albert T. Kwedar, President, presiding.

Business Session

Address: Mrs. George Turner, President, Auxiliary to the American Medical Association, El Paso, Texas

The County Presidents present: This Is Your Auxiliary

1:00 p.m. Luncheon and Fashion Show honoring the Past Presidents

Sarah Siddon Walk, Ambassador East Hotel

Chairman: Mrs. Henry Christiansen, Immediate Past President

WEDNESDAY, May 18, 1955

8:30 a.m. Registration on Mezzanine Floor

9:30 Second Delegate Session — Crystal Room on First Floor

Mrs. Albert T. Kwedar, President, Presiding

Promptness Award

Introduction of Convention Program — Mrs. Darrell H. Trumpe, Convention Chairman

SCHOOL HEALTH IN ACTION (Film) with discussion by John Lester Reichert, M.D., Chicago

PANEL — "Facts and Fallacies About the Legislative Program of the Illinois State Medical Society"

Jacob E. Reisch, M.D., Springfield — MODERATOR

Mr. Joseph Stetler, Director, LAW DEPARTMENT, American Medical Association, Chicago

Mr. James C. Leary, Director of Public Relations, Illinois State Medical Society, Chicago

One other participant — to be announced

SYMPOSIUM — An Auxiliary in Its Lair Is a Turtle or a Hare —

SANGAMON COUNTY AUXILIARY presentation

1:00- 4:00 REFERENCE COMMITTEES — Mrs. Harlan English, Vice-President, Wom-

an's Auxiliary to the American Medical Association, presiding
Guests are welcome at all reference committee meetings

THURSDAY, May 19, 1955

9:30 a.m. Third Delegate Session — Crystal Room — First Floor
Mrs. Albert T. Kwedar, presiding
Presentation of Promptness Award
Election of Officers
Memorial Services — Mrs. Carl Sibilsky, Past President, in charge

1:00 p.m. LUNCHEON honoring Mrs. Albert T. Kwedar, President, and Mrs. Warren Young, President-Elect
ADDRESS: "The Doctor and The Public"
DR. ALPHONSE McMAHON, Immediate Past President of the Southern Medical Association, St. Louis
Luncheon Chairman — Mrs. Maurice M. Hoeltgen, Chicago
Co-Chairman — Mrs. Leonard Houda, Chicago

‹‹‹ ›››

Make Plans Now To Be At This INTERESTING INFORMATIVE ENTERTAINING Meeting

MEDICAL ECONOMICS

John R. Wolff, Chairman, Walter C. Bornemeier, Edward W. Cannady, Roland R. Cross, Jr., E. F. Dietrich, W. W. Fullerton, Edwin F. Hirsch, Frederic T. Jung, W. R. Malony, Caesar Portes, William Requarth, Frederick W. Slobe.

Evolution of a Community Health Insurance Plan

WILLIAM REQUARTH, M.D., DECATUR

THE hazard of illness which can cause either loss of income or great expense makes the average individual look upon the cost of hospitalization and medical care as a threat to his security. This is probably one of the main reasons for the popularity and growth of medical care plans and more importantly is the cause for the recent general demand for full coverage pre-payment insurance plans. The C.I.O. United Steel Workers Union have made this plea through their president, David J. McDonald (Medical Economics June 1953). He cites as examples the Permanent Health Plan in California and the Health Insurance Plan (H.I.P.) of New York City.

The demand for a full coverage form of insurance is not great at present and is unlikely to become so in the near future because people in general are prosperous, times are good and the expense of illness is not pressing. The dissatisfaction with current health insurance at present to a large extent may be artificial on the part of unions. Having gone the limit on wage increases, the labor unions are turning to so-called fringe benefits and among these is health insurance. An economic slump could produce additional pressure for this form of insurance. Insurance policies which reach beyond basic protection and extend to full protection, that is, that will pay participants full expenses, both medical and hospital, will have premium rates absolutely out of reach of those that need it most. Many companies issuing unlimited service contracts have now defaulted. However, what Mr. McDonald wants is "protection and security, paid by the company."

Unquestionably, the demand for more adequate coverage will increase in the years to come and it is the responsibility of our profession to look into all aspects of this and to meet the problem with every degree of realism and facts. Policies must be tailor-made for each community. A preliminary step is the accumulation of data by a local medical society survey committee such as was conducted here in Macon County. Such a committee has a wide community group representation and is actually a cooperative venture between these individuals, the medical society, the insurance underwriters and hospitals. Among its members should be representatives of the Association of Commerce, newspapers, social welfare groups, industry, labor and farm groups. The Macon County project was initiated by the Public Relations Committee of the County Medical Society of which Dr. C. E. Bell was chairman. Subsequently, the Decatur Community Health Insurance project was organized with Dr. W. C. Smullen as chairman. Other sub-committees investigated the cost of hospital care, the cost of surgical care (surgical fees were re-

ported as high, low, and average or usual fees on a questionnaire sent to all physicians). At the same time an investigation was made of the quality of claim services. Other surveys dealt with the average overhead for practicing physicians and the investigation of the minimum criteria for an adequate policy.

One of the major purposes of this committee was to create a desire for health insurance among the people and to produce a simplified and standardized universal report form. After many weeks of work certain minimum standards for insurance in Macon County were developed, standards which then were used to set up the type of insurance coverage that would be adequate for most people. The essential features of a good policy were made known to the public to guide them in buying insurance because this had been completely inadequate in the past.

The standardized policy, providing what the committee considered adequate insurance coverage for this area, was then submitted to various underwriters for their study in formulating a policy to cover these various features. Blue Cross and Blue Shield produced a policy, the premium of which was forty to sixty dollars per year less than the nearest estimate of other companies. It was decided to accept Blue Cross and Blue Shield as the type of insurance most suitable for the public at a rate which they could pay.

Whether full coverage insurance which the unions are demanding will ever be possible on a voluntary basis seems unlikely. It is at least known that such insurance will be expensive unless it includes a deductible clause or some stated specific maximum amount of each service rendered, such as appears in many of the ordinary indemnity type of contracts today. A demand on the part of the public for this type of insurance will rise as costs rise and it is the duty of the medical profession to take the leadership and try to provide a suitable policy for low income groups at a price they can afford. The alternative to this type of aggressive action will be increasing numbers of medical centers set up by unions or centers which supply medical care on a prepaid basis, as seen in New York.

‹‹‹ ›››

Standard saline

Normal Sea Water is difficult enough to explain in English; with a limited vocabulary, it is impossible to explain in Spanish. Actually, Normal Sea Water is something like the Standard Meter in that a similar definition is provided the world over. The water in prepared at Copenhagen or at Woods Hole, Mass., and is *the* standard used in making chemical analyses to determine the degree of saltiness of sea water from place to place and depth to depth. To those engaged in the serious study of the physical and chemical structure of the oceans, a difference of as little as one ten-thousandth in the salinity between two adjoining areas is of significance. Normal Sea Water is now available to workers in all countries, so that oceanographers everywhere have the same basis for comparison and are thus on common ground in their research. *Daniel Merriman, El Nino Brings Rain To Peru. Am. Scientist, Jan.* 1955.

Meeting of the American Academy for Cerebral Palsy

The American Academy For Cerebral Palsy will hold its annual meeting in Memphis, Tennessee, October 10-12, 1955. The meetings are open to members of the medical and allied professions who are interested in cerebral palsy. The three day program will include instructional courses in the various phases of cerebral palsy as well as a formal program.

Those desiring to attend this interesting session, may procure information from Robert A. Knight, M.D., Secretary-Treasurer of the Academy. Hotel reservations are to be made directly with Mr. Scott Stewart, manager of the Claridge Hotel, Memphis, this being the convention headquarters. The President of the Academy is Dr. Lenox D. Baker, Duke Hospital, Durham, North Carolina. The address of Dr. Knight, the Secretary, is 869 Madison Avenue, Memphis 3, Tenn.

CORRESPONDENCE

Clinics for crippled children listed for May

Twenty six clinics for Illinois' physically handicapped children have been scheduled for May by the University of Illinois Division of Services for Crippled Children. The Division will count 21 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examinations. There will be 4 special clinics for children with rheumatic fever and 1 for cerebral palsied children.

Clinics are held by the Division in cooperation with local medical and health organizations, both public and private. Clinicians are selected among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or may want to receive consultative services.

The May Clinics are:

May 3 — Casey, High School
May 3 — Pittsfield, Illini Hospital
May 4 — Hinsdale, Hinsdale Sanitarium
May 5 — Monticello, Lincoln School
May 5 — Sterling, Field House
May 5 — Litchfield, Madison Park
May 10 — Peoria, Children's Hospital
May 10 — E. St. Louis, Christian Welfare hospital
May 11 — Joliet, Will County T. B. Sanitarium
May 12 — Springfield, St. John's Hospital
May 12 — DuQuoin, Marshall-Browning Hospital
May 12 — Elmhurst (Rheumatic Fever), Memorial Hospital of DuPage County
May 13 — Chicago Heights (Rheumatic Fever), St. James Hospital
May 17 — Carmi, Carmi Township Hospital
May 18 — Evergreen Park, Little Company of Mary Hospital
May 19 — Rockford, St. Anthony's Hospital
May 19 — Alton (General, Rheumatic Fever, Cerebral Palsy), Alton Memorial Hospital
May 19 — Macomb, St. Francis Hospital
May 20 — Evanston, St. Francis Hospital
May 24 — Peoria, Children's Hospital
May 24 — Effingham (Rheumatic Fever), St. Anthony's Hospital
May 24 — E. St. Louis, St. Mary's Hospital
May 25 — Springfield (Cerebral Palsy), Memorial Hospital
May 25 — Aurora, Copley Memorial Hospital
May 26 — Bloomington, St. Joseph's Hospital
May 27 — Chicago Heights (Rheumatic Fever), St. James Hospital

‹ ›

Good use for old equipment

To The Editors:

I have recently retired from active work and am spending a great deal of my time in the Southwest part of the country doing work among the Indians. In this connection, I have learned of the need for surgical instruments and other equipment to be used by medical students working among the people in the remote areas of Mexico.

It is my thought that possibly some of your members may have outdated equipment they are willing to donate for this work and I will appreciate your bringing this request to them. In greater demand are portable instruments which may be carried by jeep, horseback or plane. They would also appreciate receiving samples of ap-

proved medicines that I understand come frequently to your members, and they will be greatly appreciated by these students working among the people in the disease stricken areas in Mexico.

Larger pieces of equipment would be welcome, but inquiry should first be made before shipment. Small instruments and supplies may be sent directly to the following address; Colegio Vocacional y Professional Montemoreles, Monte Morelos, Nueva Leon, Mexico. If preferable, they may be sent to me and I shall see that they arrive at their destination. Your assistance in this matter will be greatly appreciated by myself, and by thousands of Indians and Mexicans who will benefit directly by these gifts.

O. J. Forman,
The O. J. Forman Company,
Bookbinders, Monmouth, Illinois

‹ ›

Allergists hold annual meeting

The Eleventh Annual Congress and Graduate Instructional Course in Allergy of The American College of Allergists will be held at the Morrison Hotel in Chicago, Illinois, April 25 through the 30th. The first three days will be devoted to 40 hours of intensive teaching of the basic facts in this field of medicine. These courses will be conducted by 45 specialists well known for their teaching ability and mostly chosen from the medical college faculties throughout the nation. These courses are designed to guide and stimulate physicians beginning to recognize the importance of applying present-day knowledge to their practices. This instruction will attract and hold the interest of physicians in general practice who are finding that more than 5 per cent of the people who consult them do have an allergic component in their illness.

The growing importance of drug and serum allergies will be emphasized that the more severe and fatal cases may be avoided. Those who attend will be taught how to be on the lookout for the more severe reactions in the hypersensitive patient and the danger that is ever present when chemical therapeutic agents are used.

The last two days will be devoted to more advanced clinical papers and to reports of research and investigations. The Annual Oration of the College will be given this year by Robert A. Cooke, M.D., Director of The Institute of Allergy at The Roosevelt Hospital, New York City, and one of the great pioneers in the field. His subject will be: "Medical Research in the Field of Allergy."

Any member in good standing of his local county medical society is cordially invited to attend. Further details and the program may be obtained by writing American College of Allergists, La Salle Medical Building, Minneapolis 2, Minnesota.

‹ ›

Annual meeting of American College of Chest Physicians

The 21st Annual Meeting of the American College of Chest Physicians will be held at the Ambassador Hotel, Atlantic City, New Jersey, June 1 through 5, 1955. The scientific program will include approximately 200 speakers representing specialists in all aspects of diseases of the heart and lungs. In addition to formal presentations, the program comprises a number of symposia, round table luncheon discussions, diagnostic-treatment conference and motion pictures. More than the usual amount of time has been allotted for open discussion.

A new feature this year will be the Fireside Conferences, to be presented on Friday evening, June 3. At this session more than thirty experts will be present to lead the discussions on as many subjects of current interest in the specialty of diseases of the chest.

Fellowship examinations will be held on June 2, and on Saturday evening, June 4, more than 100 physicians will receive their Fellowship certificates at the annual Convocation which will precede the Presidents' Banquet.

All interested physicians are cordially invited to attend the 21st Annual Meeting of the College; there is no registration fee. Copies of the program may be obtained by writing to the Executive Offices, American College of Chest Physicians, 112 East Chestnut Street, Chicago 11, Illinois.

NEWS of the STATE



ADAMS

Society News.—"Ectopic Pregnancy" was the subject of Dr. Nicholas M. Alter, Pathologist, at Blessing Hospital, before the Adams County Medical Society at the meeting at the Lincoln-Douglas Hotel in Quincy, February 14.

Election of Officers.—Dr. Newton DuPuy was chosen President-Elect of the Adams County Medical Society recently, and Dr. T. L. Stebbins was installed as President. Other officers are Dr. E. Hayden Keys, Jr., First Vice-President; Dr. Clifford A. Hendricks, Second Vice-President; Dr. Newton DuPuy, Secretary; Dr. Harold Swanberg, Treasurer; Dr. Walter M. Libmann, Accounting Officer; Dr. Hilliard M. Shair, Editor; Dr. Paul T. Lambertus, Medico-Legal Adviser; Dr. Hilliard M. Shair, Historian; Dr. Walter M. Whitaker, Delegate; Dr. Ralph McReynolds, Alternate Delegate; Dr. Stephen L. Casper, Counselor for three years; and Dr. Guy L. Tourney, Censor.

Public Relations Meeting.—On May 9 the Annual Medical Public Relations meeting of the Adams County Medical Society will be held at the Lincoln Douglas Hotel, Quincy. This will be an evening dinner meeting with Tom Hendricks, Secretary of the Council on Medical Service of the American Medical Association, Chicago, as the guest speaker. All physicians in the Quincy tri-state area are invited and urged to bring their secretaries, nurses, technicians, receptionists, office assistants and hospital helpers to hear the special program. All will be guests of the society for the interesting meeting and the snack bar lunch which will follow the meeting. A fellowship hour at 7:00 p.m. will open the session.

COOK

Medical Society Pays Expenses of Destitute Physician.—The funeral expenses of the late Dr. Louise M. Hovenden, who died in poverty in Chicago, were assumed by the Chicago Medical Society. The undertaker's bill was handled by the Society and other public spirited persons made contributions toward the overall expenses. This gesture was medical public relations at its best.

Mental Clinic for Children Dedicated.—Opening of a $60,000-clinic at the University of Chicago for the psychiatric treatment of emotionally disturbed children was announced (February 13) by Ray E. Brown, superintendent of the University Clinics.

The 15-room clinic, located on the fourth floor of Bobs Roberts Memorial Hospital for Children in the University Medical Center, will be equipped to handle up to 100 patients per week when full operation is reached, probably by mid-summer, Brown said.

Currently, the clinic is being decorated, furnished and equipped with toys and therapy equipment purchased with a $6,150 gift from the Service Club of Chicago.

A few patients referred by the University Clinics are now being treated, according to Dr. John F. Kenward, assistant professor of pediatrics and medicine, and director of the new clinic.

Facilities of the clinic include two children's playrooms built with one-way glass observation screens and inter-com systems, to assist the doctor in diagnosis by watching the child patient at play.

Long-range plans for the clinic involve both the treatment and diagnosis of disturbed children, and the medical training of pediatric psychiatrists and psychiatric social workers.

Membership of the Service Club of Chicago will observe the opening of the new clinic with a dinner February 18 at the Quadrangle Club. The program for the evening includes an inspection visit to the clinic by the dinner guests.

The Service Club committee in charge of the dinner consists of Mrs. William G. Caples, Mrs. Thomas Atkins Kelly, and Mrs. Chester Laing. Mrs. G. Kenneth Crowell is president of the Club.

Cecil Krakower Named Chief Pathologist.—Dr. Cecil A. Krakower, Professor of Pathology, University of Illinois College of Medicine, has been appointed head of the Department of Pathology and Pathologist-in-Chief of the Hospitals at the

medical school. Dr. Krakower, who has been a faculty member since 1944, succeeds Dr. Granville A. Bennett who asked to be relieved of the departmental headship because of his appointment as Dean of the College of Medicine.

William Mengert Heads Obstetrical Department.—Dr. William F. Mengert, Professor and Head of the Department of Obstetrics and Gynecology, Southwestern Medical School, University of Texas, has been named to a similar post at the University of Illinois College of Medicine, filling the vacancy created by the retirement of Dr. Frederick H. Falls. Until Dr. Mengert takes up his responsibilities, Dr. Vincent C. Freda, clinical assistant professor of obstetrics and gynecology, is serving as acting department head.

Warren Cole Honored.—Dr. Warren H. Cole, professor and head of the Department of Surgery, University of Illinois College of Medicine, was one of the fifty-eight alumni of Washington University School of Medicine, St. Louis, to be honored recently in recognition of outstanding achievements and service which have reflected honor upon the University. The citation to Dr. Cole was presented during the University's Second Century Convocation, marking the beginning of its second century of education and service to the St. Louis community.

Student Scholarship Fund Established.—The Solomon Citterman Scholarship Fund for students has been established at the University of Chicago School of Medicine with an initial gift of $7,500 from Mr. and Mrs. Marvin Citterman, Chicago, Dr. and Mrs. Leonard H. Harris, Peoria, and Mr. and Mrs. Bernard D. Cahn, Great Neck, Long Island, New York. The Scholarship Fund was set up in memory of the late Solomon Citterman, father of Mr. Citterman, Mrs. Harris and Mrs. Cahn. The late Mr. Citterman, founder of the Manufacturers' Ticket and Label Company, Chicago, a self-made man of limited formal education himself, during his lifetime made numerous gifts to young men and women to finance their education. His children established the scholarship as a memorial closely related to his lifelong interest in helping ambitious young people, according to a release from the University of Chicago.

Income from the fund will be awarded annually to medical students in need of financial assistance. Selection of the recipient of the scholarship will be made by the University's scholarship committee on the basis of a student's academic record and financial need.

Passavant to Add Eighty-five Beds.—Three million dollars will be expended to construct an addition and provide extensive remodeling of present facilities at Passavant Memorial Hospital. Ground breaking ceremonies for the new wing are expected to take place in November, newspapers report. The addition will extend south from the present building at 303 East Superior Street with a four-floor section housing supporting services, such as laboratories, an X-ray department, business offices, kitchen, dining rooms, storage accommodations, shops and a laundry. The eastern part of the unit will be ten stories high and connect with the present east wing. This section will be devoted to patient care and will add eighty-five beds to the hospital's present 263-bed capacity. The top floor of the new addition will house surgical, X-ray and laboratory departments, together with a blood bank. The plans also include provisions for a psychiatric department, a clinical research unit, an eye section, and other specialized facilities which now are either lacking or inadequately served because of space limitations.

Personal.—A distinguished service plaque has been presented by the Sisters of St. Francis Hospital to Dr. Clifford G. Grulee, Evanston, organizer of its department of pediatrics in 1930. Dr. Grulee is honorary president of the American Academy of Pediatrics.—Dr. Edward M. Dorr has been elected chairman of the joint maternal welfare committee of Cook County, permanent advisory group to the Chicago Board of Health on matters relating to infant and mother care.—Dr. Lorne W. Mason, consulting surgeon at St. Francis Hospital, recently was named chairman of the North Shore Chapter of the American Cancer Society.—Dr. Dwight J. Ingle, division of Biological Sciences, University of Chicago, has received a grant to support work on the study of the mechanisms of hormone action upon growth and metabolism.—Dr. B. Barker Beeson, Chicago, has been elected a member of the Association of French Speaking Dermatologists of Paris, France.—Dr. Karl A. Meyer, medical superintendent of county institutions, has been elected president of the Board of the Chicago Foundlings Home.—Drs. Walter Schiller, August F. Daro, Harvey A. Gollin, and Ernest G. Nora, Jr., won first award for their Scientific Exhibit on "Early Cervical Carcinoma: Types of Growth and Development." The exhibit won the award during the Sixth American Congress on Obstetrics and Gynecology, sponsored by the American Academy of Obstetrics and Gynecology recently.

Society News.—The Society of Medical History of Chicago was addressed March 8 by Dr. Alfred Kobak, Associate Clinical Professor of Obstetrics and Gynecology, University of Illinois College of Medicine, on "Evolution of Cesarean Section;" Dr. A. Rostenberg, Jr., Professor of Dermatology, University of Illinois College of Medicine, on "The Development of Knowledge Concerning Poison Ivy;" and Dr. B. Barker Beeson, Professor Emeritus of Dermatology and Syphilology, Stritch School of Medicine, Loyola University, on "Joseph Souberbielle, Surgeon and Revolutionist."—The following program was presented before the Chicago Pediatric Society: Dr. Arthur W. Fleming, "Range of Motion of the Shoulder and Hip Joints in the Newborn Infant"; Dr. Bernard G. Sarnat, "Clinical and Experimental Considerations of Normal and Abnormal

Growth of the Face and Jaws;" and Dr. Paul Hurwitz on "Strabismus in Childhood."—The Chicago Neurological Society was addressed March 8 by Dr. S. J. Lipnitzky on "Etiological Coexistence of Erythroblastosis Fetalis and Retrolental Fibroplasia in Oligophrenia;" Dr. S. Pruzansky on "Cephalometric Studies of Interest to Neurologists;" Drs. P. R. Rosenbluth and H. J. Grossman on "Congenital Midline Dysplasia of the Scalp;" and Dr. H. H. Merritt on "Some Reflections on the Pathogenesis of Convulsive Seizures."—The Chicago Society of Physical Medicine and Rehabilitation was addressed recently by Harold Westlake, Ph.D., Northwestern University School of Speech Pathology, on "Physiological Structural Support for Speech," and Joseph Wepman, Ph.D., University of Chicago, on "Recovery of Language as Related to Rehabilitation of Aphasic Patients."—Dr. Maurice H. Cottle, Professor and Head of the Department of Otolaryngology, Chicago Medical School, conducted a seminar on "Septum and Rhinoplastic Surgery" at the University of Ohio School of Medicine, Columbus, recently.—Dr. Louis B. Newman, Chief of Physical Medicine and Rehabilitation, Veterans Administration Research Hospital, Chicago, addressed the entire staff of the Veterans Administration Hospital, Phoenix, Arizona, February 17, on "Physical Medicine and Rehabilitation is Part of Total Medical Care."

Gift of $150,000 to Medical School.—The Max and Leola S. Epstein Foundation has presented The Chicago Medical School with a gift of $150,000. The gift continued the tradition of supporting educational and medical research institutions for which Max Epstein, late Chairman of the National Board of Governors of The Chicago Medical School, was well known in his lifetime.

Changes in Faculty.—Ten recently-promoted members of the Chicago Medical School faculty are Dr. Russell von Milliser to Professor of Pathology; Dr. Jerome Fishman, Clinical Assistant Professor of Otolaryngology; Dr. Harold S. Feinhandler, Clinical Associate in Ophthalmology; Dr. Seymour Greenwald, Clinical Associate in Otolaryngology; Dr. Harold Klehr, Associate in Psychiatry; Dr. Julius J. Prohovnik, Clinical Associate in Otolaryngology; Dr. Samuel I. Weiner, Clinical Associate in Orthopedic Surgery; Dr. Alex M. Berman, Clinical Instructor in Otolaryngology; and Dr. Irwin Dvore and Dr. Harold Kamenear, Clinical Instructor in Medicine.

Dr. James E. P. Toman, Director of Neurophysiological Research at the Institute for Psychosomatic Research and Training, Michael Reese Hospital, has been appointed to the faculty as a full-time Assistant Professor of Anatomy. Dr. Harry J. Lipner has also received a full-time appointment as Instructor in Clinical Pathology. Newly appointed to the Department of Medicine are Dr. Johann S. Bornstein, Associate in Clinical Medicine; Dr. Herman M. Pomrenze, Clinical Instructor in Medicine; and Dr. Louis C. Curuso, Dr. Marvin M. Hirsch, Dr. Jerome Kaiser, Dr. Sidney Mintzer, Dr. Ernest Mond, and Dr. David Nusbaum, Clinical Assistants in Medicine. Appointed to the Department of Surgery at the same time are Dr. Julius H. Bolgla, Dr. Ian E. Gordon, and Dr. Leonard Kernis, Instructors in Anesthesiology; and Dr. Jack H. Sanders and Dr. Jerome M. Silver, Clinical Instructors in Surgery. Other departmental appointments are Dr. Bernard P. Resnik, Clinical Assistant in Ophthalmology, and Dr. Ellis D. Johnson, Clinical Assistant in Psychiatry.

Symposium on Growth.—The Sigma Xi Club of the Chicago Medical School sponsored a symposium on growth at the school, February 9. Speakers were John J. Chiakulas, Ph.D., Instructor in Anatomy, Chicago Medical School, on "What Is Growth?"; Aaron Novick, Ph.D., Assistant Professor of Microbiology and Committee on Biophysics, University of Chicago, "Regulation of Bacterial Growth Rate"; Delbert Bergenstal, Ph.D., M.D., Assistant Professor of Medicine, University of Chicago, "Growth Hormone As A Factor In Somatic Growth"; and Michael B. Shimkin, M.D., Chief, Biometry and Epidemiology Branch, National Cancer Institute, "Growth in Animal Lung Tumors."

Progress in Endocrinology.—The Chicago Medical School sponsored a lecture series recently on the progress in endocrinology. The following participated: Dr. Harry F. Weisberg, Assistant Professor of Clinical Pathology and Clinical Medicine, The Chicago Medical School, on "Thyroid Hormones"; Dr. Rachmiel Levine, Chairman of the Department of Medicine, Director of Metabolic and Endocrine Research, Michael Reese Hospital, on "Adrenal Steroids"; Dr. Richard W. Schayer, Research Associate, Rheumatic Fever Research Institute, Northwestern University, on "Epinephrine and Nor-Epinephrine"; Dr. Maurice E. Krahl, Professor of Physiology, University of Chicago on "Insulin"; Dr. Allan T. Kenyon, Professor of Medicine, University of Chicago, on "Androgens"; and Dr. Gordon S. Steward, Assistant Professor of Biochemistry (Rush), University of Illinois; Associate Attending Biochemist, Presbyterian Hospital, on "Parathyroid Hormone."

DuPAGE

Women's Auxiliary Formed.—Mrs. Armand J. Mauzey, Elmhurst, is the new President of the recently formed Women's Auxiliary to the DuPage County Medical Society. Other officers are Mrs. Dan Jamison, Wheaton, Corresponding Secretary; Mrs. C. R. Snead, Elmhurst, Treasurer; Mrs. H. Richard Bowman, Itasca, Vice-President. Mrs. Alan S. Watson, Glen Ellyn, was named President-Elect for the 1956 term and Membership Chairman for 1955. Mrs. Warren W. Young, Chicago, President-Elect of the Women's Auxiliary of the Illinois State Medical Society, and Mrs. Albert Kweedar, Spring-

field, President to the State Auxiliary, assisted in the installation of the new officers. One hundred dollars was given to the Auxiliary by the DuPage County Medical Society.

KNOX

Society News.—Dr. Joseph Sherrick, Associate in Pathology, Northwestern University Medical School, Chicago, and a native of Monmouth, discussed "Cardiac Arrest" for the Knox County Medical Society at the Galesburg Club recently. At the business session, the Society considered plans for acting host to the post-graduate conference sponsored by the Post-graduate Education Committee of the Illinois State Medical Society in Galesburg on April 20.

LAKE

New Officers.—Dr. Douglas Boyd, Highland Park, was elected President of the Lake County Medical Society at a recent meeting. Other officers are Dr. John Milroy, Lake Forest and Waukegan, Vice-President; Dr. M. J. McAndrew, Lake Bluff, Secretary; Dr. Ray C. Johnston, Waukegan, Treasurer. Dr. Robert M. Watrous, Highland Park and North Chicago, was named to the Board of Censors, and Dr. Donald Douglas, Waukegan, Chairman of the Grievance Committee; Dr. Ralph Bettman, Highland Park, a member of the Committee for a one-year term. Drs. William R. Darnall, Waukegan, and Gerrit Dangremond, Waukegan and Lake Bluff, were elected to three-year terms. Dr. Donald C. Nellins, Waukegan, was named delegate to the Illinois State Medical Society and Dr. George Simonian, Waukegan, alternate delegate.

MACON

Society News.—Floyd Barringer, M.D., Springfield, addressed the Macon County Medical Society, February 22, at the Decatur Club; his subject was "Practical Aspects in the Treatment of Head Injuries."

County Society Takes Quarters in Hospital.—Permanent Quarters have been made available in St. Mary's Hospital for offices of the Macon County Medical Society. The space was made available through an offer of Sister Jane, administrator of St. Mary's Hospital. The Society has employed a part time secretary who will work a minimum of three half-days each week. Mrs. Mary Lamar has been employed in this capacity.

The Society also plans to donate annually approximately $150 each to the libraries of the Decatur and Macon County and St. Mary's Hospitals. The amount of this donation is subject to revision at any later date by vote of the society, according to the Bulletin of the Macon County Medical Society. The funds shall be used first, to subscribe to the desired, necessary journals not now available in either library, and second, to help underwrite the binding costs of the journals in the libraries. Bills for such subscriptions and binding expenses are to be submitted annually to the Macon County Medical Society Library Committee for approval and payment. Other stipulations concerned the housing, distribution and expansion of subscriptions to publications. These changes are subject to the approval of the Library Committee of the County Medical Society, which is composed of one or two members from each hospital staff together with a member representing the medical society.

MADISON

New Officers.—Dr. Charles D. Ehlert, Alton, was installed as President of the Madison County Medical Society recently. Other officers are Dr. Robert Anschuetz, Alton, President-Elect; Dr. E. F. Moore, Collinsville, Secretary; Dr. L. H. Konzen, Wood River, Treasurer; and Dr. Ewald Hermann, Highland, Medico-legal Member. Dr. Cecelia Hellrung, Edwardsville, outgoing President of the Society, was named to the Board of Censors and members of the Ethical Relations Committee now consist of the following: Drs. G. F. Moore, Alton; W. W. Brown, Collinsville; W. E. Delicate, Edwardsville; L. L. Grzesk, Granite City; H. A. Mittleman, East Alton.

Society News.—Dr. William B. Seaman, St. Louis, Associate Professor of Radiology, Washington University School of Medicine, addressed the Madison County Medical Society, March 3, on "Intracavitary Radiation with Colloidal Gold."—"Problems in Anesthesia" was the subject of Drs. William R. Wicks and Joseph M. Dondanville, both of Alton, in addresses before the Madison County Medical Society at St. John's Methodist Church, Edwardsville, recently.

ROCK ISLAND

Society News.—Dr. William H. Requarth, Decatur, addressed the Rock Island County Medical Society at its March meeting on "Intestinal Obstruction."

SANGAMON

Society News.—Dr. A. N. Arneson, Associate Professor of Clinical Radiology and Clinical Obstetrics and Gynecology, Washington University School of Medicine, St. Louis, addressed the Sangamon County Medical Society at St. John's Hospital, January 6, on "Radioactive Colloidal Gold in the Treatment of Carcinoma."

VERMILION

Society News.—Dr. W. D. Snively, Jr., Vice-President and Medical Director of Mead Johnson and Company, Evansville, Indiana, addressed the Vermilion County Medical Society recently on "Simple Approach to Clinical Fluid Balance."

New Officers.—Dr. E. M. Dewhirst was named President of the Vermilion County Medical Society at its recent meeting. Dr. Martha S. Parker was elected Vice-President; Dr. L. W. Tanner, Secretary-Treasurer. Dr. Jean W. Moore was named Delegate to the Illinois State Medical Society, and Dr. A. R. Brandenberger, Alternate. Dr. Harlan

English is Councilor for the Eighth District which includes Vermilion County.

WINNEBAGO

Blood Bank Fee Reduced.—Effective December 1, 1954, the Blood Bank Board of Directors of Winnebago County announced a reduction in the cost of a unit of blood to members. The announcement marks the second anniversary of the Blood Bank's operation. The project was launched with a service charge of $10.00. The fee is now $7.50. The cost to non-members will remain at $30.00, but this cost may be reduced to $10.00 by replacing two units of blood for each unit received, according to the Bulletin of the Winnebago County Medical Society. Mr. George Hagney, who has been the chief technician of the Blood Bank, was promoted to Manager recently. Dr. Paul Van Pernis, Rockford, will continue as Medical Director of the Blood Bank.

Weight Control Project Continued.—The Weight Control Program, launched in Winnebago last year with the co-operation of the Council of Social Agencies and the Winnebago County Medical Society, will be continued this year. The classes opened in February. Each person is charged $2.00 for the eight sessions to defray the costs entailed in presenting the program. All persons wishing to join the classes will be required to have an application form completed by their family physician before they are accepted. The forms are available through the office of the Winnebago County Medical Society.

GENERAL

Visiting Lecturer on Medical Writing Named.—Dr. Jacques P. Gray, Director of Special Medical Services and Medical Consultant of Parke, Davis & Company, Detroit, Michigan, has been appointed Visiting Lecturer on Medical Writing of the American Medical Writers' Association. This new appointment culminated as a result of a paper presented before the Chicago meeting of the American Medical Writers' Association by Dr. Harold Swanberg, Quincy, Secretary of the Association, entitled "A Medical Journalism Scholarship Fund and a Traveling Lectureship for the American Medical Writers' Association."

Dr. Gray's efforts will be devoted to instruction in medical writing to medical students and to the interns and residents in the leading teaching hospitals of the United States and Canada. An itinerary for Doctor Gray is being worked out by the Association of American Medical Colleges. The entire expense of this pioneer educational work in medical writing for the students of medicine will be borne by Parke, Davis & Company, Detroit.

Raymond Robertson Named Superintendent.—Governor William G. Stratton has appointed Dr. Raymond E. Robertson as Superintendent of the Institute for Juvenile Research, Chicago. The appointment was made on the recommendation of Dr. Otto L. Bettag, Director of the State Department of Welfare.

The Institute for Juvenile Research provides facilities for diagnostic study and treatment for emotional disturbed or socially maladjusted children and their parents in an outpatient clinic in Chicago and in 17 regional clinics throughout the state. It also provides consultation in child psychology and child guidance in schools and social agencies, as well as instruction for mental health workers.

New Psychiatric State Hospital Planned.—Plans are underway to build a five-million dollar Psychiatric Institute state hospital on Chicago's west side, newspapers have announced. It is hoped that ground will be broken on the project some time this year, but construction will take about two years. The hospital, which is to be a center for acute, intensive treatment, will have 400 to 500 beds. It will provide teaching facilities to the University of Illinois College of Medicine, Northwestern University Medical School, the University of Chicago School of Medicine, Stritch School of Medicine of Loyola University, the Chicago Medical School, the Chicago Institute for Psychoanalysis and the Michael Reese Hospital Psychosomatic Institute. Funds for the hospital will come from the mental health fund, representing money collected from relatives of patients in state hospitals as partial reimbursement for the expense of caring for such patients. The Chicago firms of Shaw, Metz & Dolio, and Fugard, Burt, Wilkinson & Orth are the architects.

Neuromuscular Diseases of Children.—A course in the neuromuscular diseases of children with emphasis on cerebral palsy will be offered by Dr. Meyer A. Perlstein at the Cook County Graduate School of Medicine in Chicago, June 20-July 1. This is an intensive two-week didactic and clinical course in the diagnosis and management of the neuromuscular diseases of children with special emphasis on cerebral palsy and includes field trips to itinerant clinics. Registration, which is limited, may be made by applying to the Registrar, Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, Illinois. Tuition is $225.00 which includes the costs of luncheons during the course and the cost of transportation and hotels during itinerant clinics.

Anton Carlson Honored.—Dr. Anton J. Carlson, world famed physiologist from the University of Chicago, was unanimously elected Honorary President for Life of the National Society for Medical Research at the Society's recent annual meeting. Dr. Carlson, who had been president of the Society since its inception in 1946, turned the active leadership of the Society over to Dr. Lester J. Dragstedt, chairman of the department of surgery of the University of Chicago. Dr. Maurice Visscher, chairman of the department of physiology at the University of Minnesota medical school, Minneapolis, was elected Vice-President, and Dr. Ralph Gerard, director of research at the Illinois Neuropsychiatric Institute, Chicago, continued in office as Secretary-Treasurer.

Carl Hedblom's Memory Honored.—Dr. Edward J. Beattie, Chairman of the Department of Surgery

and Chief of Thoracic Surgery at Presbyterian Hospital, Chicago, delivered the annual lecture sponsored by the Phi Beta Pi Medical Fraternity, March 2. This year the lecture honored the late Dr. Carl Hedblom who, until his death, was head of the Department of Surgery at the University of Illinois College of Medicine. Doctor Beattie's subject was "Problems in Thoracic Surgery."

Vital Statistics for Illinois.—A total of 206,813 babies were born to Illinois mothers during 1953, almost 1,400 more than in 1952, according to the Health Statistics Bulletin released by the Bureau of Statistics of the Illinois State Department of Public Health. In the past eight years when the birth rate has been 22 per thousand population or better, well over a million and a half live births have taken place among residents of Illinois. The fact that the birth rate has stayed high is significant because the population base is increasing fastest for children and for the aged, with a declining proportion of women reaching child bearing age. In recent years the tendency has been toward larger families with a great many second, third, and fourth births taking place in a family which formerly settled on fewer children.

The 1953 live birth rate of 22.9 does not differ significantly from the 1952 rate of 23.0 and is just barely more than the 1951 rate of 22.7. While last year's birth rate falls short of the 1947 record of 24.2 per 1,000 population, the total number of live births in 1953 exceeds the 1947 total by more than 10,000. When the rates by race are inspected, it is found that the white rate has been fairly constant over the last four years: 1950, 21.0; 1951, 21.9; 1952, 22.1; and 1953, 21.7; while the nonwhite rate has increased each year from the 1950 rate of 29.9 to 36.6 in 1953.

The rapid decline in infant and maternal mortality which took place in the 1940's is over, at least for the time being. In each of the past four years, there have been about five maternal deaths for every 10,000 live births. In 1953 and 1950 there were twenty-six infant deaths per 1,000 live births, while in 1952 and 1951 the figure was twenty-five. Similarly, neonatal mortality (death under twenty-eight days of age) kept steady around eighteen deaths per 1,000 live births.

The white infant death rate decreased from 24.4 in 1950 to 23.5 in 1953, while the nonwhite rate increased from 35.6 to 41.5. The net effect of these opposite trends produced a rate of 25.8 for all races in 1953, virtually the same as the 1950 rate of 25.6. The proportion of nonwhite infant deaths increased from fourteen per cent to twenty per cent, while nonwhite births rose from eleven per cent to twelve per cent.

Of the 5,326 deaths, seventy-six per cent were due to congenital malformations and certain diseases peculiar to early infancy. Postnatal asphyxia and atelectasis accounted for 1,345 deaths, one fourth of all infant deaths.

Death claimed 96,607 residents of Illinois during 1953, 2,400 more than in 1952. However, the crude death rate of 10.7 per 1,000 population is not significantly greater than the rate of 10.6 for 1952 and 1950, and is only slightly more than the 10.5 for 1951. For the past four years the general death rate has averaged 10.6 deaths per 1,000 population. For the United States as a whole, the rate has been a steady 9.6 during these years. These rates are the lowest in all of United States and Illinois history, and the fact that they have been maintained in the face of rapid increase in the number of aged makes it a particularly fine record.

During 1953, white persons died at the rate of 10.6 per 1,000 white population, while the nonwhite rate was 12.2. In 1940, the corresponding race specific rates were 10.9 for the white race, and 15.7 for nonwhite. This represents only a three per cent reduction in the white crude rate, while the nonwhite rate has experienced a twenty-two per cent reduction from 1940. The more rapid reduction in nonwhite mortality has steadily been diminishing the mortality differential between the two races.

Although the crude death rate has remained relatively stable for the past few years and is only sixteen per cent lower than the 1920 crude rate of 12.7 per 1,000, a rather remarkable reduction in mortality has actually occurred. When the age composition of the population is taken into consideration, the reduction in the 1953 death rate from that of 1920 is forty per cent. The 1953 crude rate is only three per cent less than the 1930 crude rate of 11.0 per 1,000, but when the rates are age adjusted for population composition it may be seen that the actual risk in 1953 is thirty per cent less than in 1930.

The decrease in mortality has not been the same for both sexes. Female mortality has always been less than that for males; however, the differential between the sexes is increasing because the female risk of dying is being reduced faster and more steadily than the male risk. Adjusted for age, the 1920 female rate was ten per cent below the male rate; while in 1953, the female rate was thirty-four per cent below. During the last thirty-five years the male adjusted rate has been reduced thirty-one per cent, and the female rate fifty per cent.

"All About Baby" on WGN-TV.—Since the last issue of the Illinois Medical Journal, the following physicians have appeared on the telecast "All About Baby" on WGN-TV, Channel 9. All physicians are invited through the **Educational Committee** of the **Illinois State Medical Society:**

Bert I. Beverly, member of the staff of Children's Memorial Hospital, March 2, 1955.

Ellis H. Harris, attending pediatrician, St. Francis Hospital, Evanston, March 9.

Arthur W. Fleming, assistant clinical professor of pediatrics, Stritch School of Medicine of Loyola University, March 16.

John R. Wolff, chairman, department of obstetrics and gynecology, Henrotin Hospital, March 23.

Robert J. Wirtshafter, member of the pediatric staff of Woodlawn Hospital, March 30, 1955.

Sidney W. Robin, member of the pediatric staff of Michael Reese Hospital.

Lectures Arranged Through the **Scientific Service Committee** of the **Illinois State Medical Society:**

Jack Fischer, Chicago, La Salle County Medical Society in Ottawa, January 13, on Milestones in Cardiology.

Harlan English, Danville, Iroquois County Medical Society in Watseka, January 18, Diseases of the Genito-Urinary Tract.

William H. Requarth, Decatur, La Salle County Medical Society in La Salle, March 10, on Injuries of the Hand.

Hans Von Leden, Evanston, La Salle County Medical Society in Streator, April 14, on Maxillo-Facial Injuries.

James E. Segraves, Chicago, Iroquois County Medical Society in Watseka, April 19, on Common Orthopedic Problems.

Harvey White, Chicago, Whiteside-Lee County Medical Societies in Rock Falls, April 21, on Pediatric Radiology.

Robert J. Patton, Springfield, Henry County Medical Society in Kewanee, May 11, on Surgery in the Aged.

John L. Reichert, Chicago, Stock Yards Branch to the Chicago Medical Society, May 13, on Immunization of Infants and Children.

Ormand C. Julian, Chicago, Douglas Park Branch to the Chicago Medical Society, May 24, on Arterial Surgery.

Lindon Seed, Chicago, Lee-Whiteside County Medical Societies, May 26, in Dixon, on Present Status of Diagnosis and Therapy of Diseases of the Thyroid.

DEATHS

Mandel A. I. Cohen*, Chicago, who graduated at Chicago College of Medicine and Surgery in 1916, died February 27, aged 59. He had practiced medicine in Chicago for more than 35 years.

Alden R. Denny*, Griggsville, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1901, died recently, aged 81.

Anton F. Fehr*, Chicago, who graduated at Magyar Királyi Pázmány Petrus Tudományegyetem Orvosi Fakultasa, Budapest, in 1913, died February 13, aged 65.

Harold V. Gould*, Chicago, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1912, died February 22, aged 65. He was certified by the American Board of Internal Medicine and a member of the board of directors of Ravenswood Hospital.

Ernest Elmer Granger, Ottawa, who graduated at Baltimore Medical College in 1903, died December 27, aged 77, of cancer. He was also a pharmacist.

Cyrus H. Irvin*, Champaign, who graduated at St. Louis College of Physicians and Surgeons in 1906, died recently, aged 77.

James Robert Irwin*, Springfield, who graduated at Keokuk Medical College, College of Physicians and Surgeons, in 1906, died January 21, aged 77. He was also a pharmacist.

Merrill R. Jacobs*, Chicago, who graduated at Rush Medical College in 1925, died February 27 at the Veterans Administration Hospital, Hines, aged 54.

Richard George Johnson, Rockford, who graduated at Rush Medical College in 1924, died in the Veterans Administration Hospital, Hines, December 30, aged 58.

Maxwell B. King, Chicago, who graduated at Harvard Medical School in 1900, died February 18, aged 83. He had practiced medicine in Chicago more than 50 years.

Florimond J. LeBlanc*, Elgin, who graduated at Bennett Medical College in 1912, died March 7, aged 70.

John Albert Malley*, Quincy, who graduated at St. Louis College of Physicians and Surgeons in 1911, died January 20, aged 67.

Corwin Spencer Mayes*, Springfield, who graduated at St. Louis University School of Medicine in 1914, died January 11, aged 67. He was a member of the staff of St. John's Hospital and past president of the Sangamon County Medical Society.

Harold Francis McCall*, Dixon, who graduated at Loyola University School of Medicine in 1936, died December 30, aged 45, of coronary thrombosis and hypertension.

Harold O. Meisenheimer*, Arlington Heights, who graduated at the University of Illinois College of Medicine in 1935, was killed, March 6, when his plane crashed in Waukesha County, Wisconsin. He was 45 years of age.

Morris I. Tir, Chicago, who graduated at the Chicago College of Medicine and Surgery in 1912, died February 25, aged 72. He was a member of the staff of the County Jail for 25 years and also on the staff of the Norwegian American Hospital.

Philip Sheridan Waters*, Bethalto, who graduated at Barnes Medical College, St. Louis, in 1903, died October 8, aged 75, of acute bronchopneumonia. He served as managing officer of the state hospitals at Alton, East Moline, and Peoria, and of the Lincoln (Illinois) State School and Colony. He was a member of the Fifty Year Club of the Illinois State Medical Society.

William W. Williams*, Quincy, who graduated at the State University of Iowa College of Medicine in 1884, died February 12, aged 94.

* Member Illinois State Medical Society.

ILIDAR 'ROCHE'

WELL-TOLERATED VASODILATOR

for relief of aching, numbness, coldness, and blanching of the extremities due to vasospasm

PROPERTIES..... Ilidar relieves vasospasm and increases peripheral circulation by (1) direct vasodilation, and (2) adrenergic blockade, i.e., sympatholysis, adrenolysis, and epinephrine reversal.

INDICATIONS..... Peripheral diseases characterized by vasospasm, e.g., Raynaud's Disease, thromboangiitis obliterans, arteriosclerosis obliterans, endarteritis, postphlebitic syndrome, etc.

CONTRAINDICATIONS..... There are no known absolute contraindications. Use cautiously in the presence of asthma, coronary disease, cardiac decompensation, and peptic ulcer. Transient postural hypotension may result from overdosage.

DOSAGE..... One 25 mg tablet t.i.d., gradually increased as necessary (recommended maximum dosage, 300 mg daily).

HOFFMANN-LA ROCHE INC • ROCHE PARK • NUTLEY 10 • NEW JERSEY

ILIDAR® *Phosphate—brand of azapetine phosphate (6-allyl-6, 7-dihydro-5H-dibenz[c, e]azepine)*

BOOK REVIEWS

VISUAL ANATOMY, THORAX & ABDOMEN by Sydney M. Friedman, M.D. Ph.D., Professor of Anatomy, University of British Columbia, Vancouver, Canada; Formerly Associate Professor of Anatomy, McGill University, Montreal, Canada.

This is a thin volume and is as its title states primarily a visual presentation with the written word supplementary. Its primary value obviously is found in the use by those who find it necessary to review or revise their knowledge of Anatomy in a limited length of time. For this purpose its publication is well justified.

203 pages, 91 illustrations. Published by Charles C. Thomas, Springfield, Illinois. $7.50.

C.P.B.

‹ ›

PROGRESS IN CLINICAL SURGERY. Edited by Rodney Smith, M.S., F.R.C.S. Surgeon, St. George's Hospital, London.

This small volume is of English origin and is printed in Great Britain. It is a symposium, twenty authorities of the highest caliber having prepared the script. The preface and prospectus of the book state that this work is of help, particularly to the postgraduate student working for his final examination. It is of value also for the one reviewing for Board examination. It is thus intended to supplement and not to replace standard surgical text books.

The writers have attempted to bring in many phases of newer aspects of clinical surgery developed in the few recent years, subjects not found in the usual standard text books.

The volume is readable. It is not verbose. It is not too easy to read but the diagnostic illustrations are understandable.

Published by Little, Brown & Co., 414 pages with 112 illustrations. $7.50. C.P.B.

‹ ›

A PRIMER OF CARDIOLOGY. Second Edition Lea & Febiger Philadelphia 1953 pp. 339, 214 Illustrations

This new textbook, now in its second edition, makes a subtle transition for the student between the study of basic science and clinical cardiac disease. Its orientation in physiology and pathology is sound medicine and good pedagogy. Still, many students will need supplementary texts which develop clinical syndromes out of patients' complaints and findings.

The author's style is direct and free from ambiguity. In some instances, however, highly controversial subjects (anticoagulant therapy, surgical lysis of rheumatic pericardial adhesions, use of long acting vasodilators and sedatives in angina, the liberal use of morphine in congestive heart failure and the use of alcohol and tobacco by cardiac patients) are discussed with only the author's personal conclusions. Whether these conclusions are valid or not, the student is handicapped when he cannot anticipate strong conflicting opinions which he will meet elsewhere. The didactic presentation makes this book easy to read, but oversimplifies some problems which require personal decision while the evidence is yet incomplete.

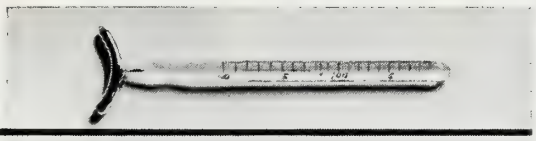
The book's general high quality suits it well for beginners in cardiology and also for older cardiologists who need reorientation in cardiac physiology. Electrocardiography is not discussed. Unfortunate oversights in proofreading have

(*Continued on page* 58)

℞ phenobarbital | *the modern way*

'Eskabarb' Spansule capsules

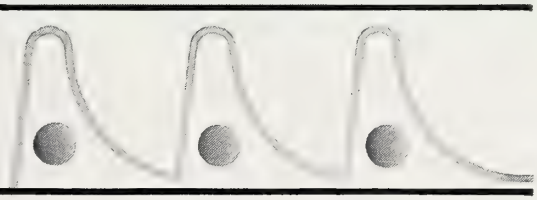
You wouldn't use this antique thermometer in your practice →



But you do use a modern one similar to this →



So why use an old-fashioned method of prescribing phenobarbital that produces "peak and valley" sedation like this? →



When you can prescribe 'Eskabarb' *Spansule* capsules—the modern form of phenobarbital that produces uninterrupted sedative action like this →



With 'Eskabarb' *Spansule* sustained release capsules, medication is released gradually and uninterruptedly throughout the day or night, providing smooth, prolonged sedation for 10 to 12 hours. 'Eskabarb' *Spansule* capsules are indicated for all conditions in which continuous, even sedation is beneficial—particularly: insomnia, restlessness or irritability, anxiety states, hypertension, epilepsy.

for continuous, uninterrupted sedation

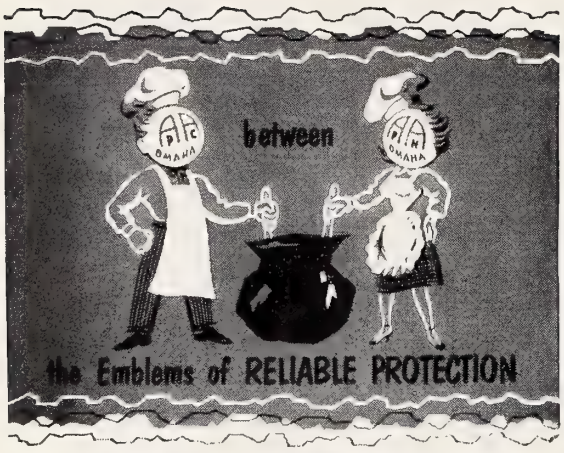
available in two strengths
1 gr. (1 dot on capsule) and
1½ gr. (2 dots on capsule)

℞ Eskabarb*
phenobarbital, S.K.F.
Spansule*
brand of sustained release capsules

made only by
Smith, Kline & French Laboratories, Philadelphia
the originators of sustained release oral medication

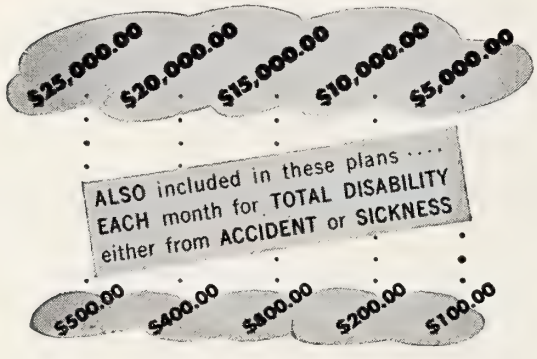
*T.M.Reg.U.S.Pat.Off. Patent Applied For

Something NEW is Cooking



MORE INSURANCE NOW AVAILABLE

think! HOW THESE AMOUNTS WOULD HELP IN PAYING ESTATE TAXES IN CASE YOU ARE ACCIDENTALLY KILLED...



SPECIFIC BENEFITS ALSO FOR LOSS OF SIGHT, LIMB OR LIMBS FROM ACCIDENTAL INJURY

$4,000,000 Assets
$20,000,000 Claims Paid
52 Years Old

Physicians Casualty & Health Ass'ns.
Omaha 2, Nebraska

Book Reviews (continued)

marred the book's general excellence and will probably be corrected in subsequent editions.

W.W.

‹ ›

SPATIAL VECTORCARDIOGRAPHY. Lea & Febiger. Philadelphia 1953 pp. 173, 121 Illustrations

This new introduction to vectorcardiography is a book for reading rather than for reference. Its lucid style is facilitated by orientation with familiar scalar electrocardiography, and by avoiding complicated and unfamiliar electro-physical and mathematical explanations. The book is an excellent route to understanding vectorcardiographic theory, technique, and interpretation. Its well selected, short bibliography guides the reader to further pertinent significant information.

Although the authors discuss other reference frames for vectorcardiography, including Duchosal's rectangular and Grishman's cubic reference frames, they utilize the equilateral tetrahedron of Wilson because it is simple to employ technically. The Einthoven triangle forms the frontal plane allowing all data available from limb leads to be applied to vectorcardiography. Mathematical and theoretical calculations are simple. The validity of their stereoscopic construction, with resistances, from two frontal plane projections may be questioned.

The vectorcardiogram can be obtained by graphic construction, manually or with special instruments, from simultaneously made scalar electrocardiograms; but the authors demonstrate that slight errors in timing may produce serious distortions in the construction of one from the other. The cathode ray tube has provided greater accuracy and simplicity of adjustment and use than all other methods for vectorcardiography. Certain findings are more apparent in vectorcardiograms than in the conventionally recorded electrocardiograms.

The special vectorcardiogram does not replace the electrocardiogram. It is still in the experimental stage. Practical applications can be expected in the near future. At present it greatly facilitates our understanding of conventional electrocardiography. W.W.

(*Continued on page 62*)

for Highest Potency • Wide Spectrum
Highest Blood, Plasma & Tissue Levels
Safety • Minimal Side Effects* • Economy

unexcelled among sulfa drugs . . .

*Few therapeutic agents, and none of the other sulfas, can claim the same degree of freedom from toxic side effects offered by the Triple Sulfas. The use of only a fractional dosage of each component sulfa drug reduces the possibility of undesirable side effects to an absolute minimum. No case of agranulocytosis has been reported resulting from their use.

Because they are so well tolerated, because of their wide spectrum of effectiveness and their outstanding economy, the Council-accepted Triple Sulfas are now more widely used than any single sulfa drug.

Triple Sulfas, alone or in combination with certain other agents, are available from leading pharmaceutical manufacturers under their own brand names. This message is presented on their behalf.

TRIPLE SULFAS

Meth-Dia-Mer Sulfonamides



All Sulfas are not Triple Sulfas!
ASK ANY MEDICAL REPRESENTATIVE ABOUT THE TRIPLE SULFA PRODUCTS HIS COMPANY OFFERS!

Cyanamid Fine Chemicals

AMERICAN Cyanamid COMPANY Fine Chemicals Division, 30 Rockefeller Plaza, New York 20, N. Y.

Another Lederle "First"!

MUMPS VACCINE

A practical immunizing antigen for prevention of mumps in children or adults where indicated. Immunizes for about one year.
Packages: 2 cc. vial (1 immunization),
10 cc. vial (5 immunizations).

LEDERLE LABORATORIES DIVISION
AMERICAN Cyanamid COMPANY
PEARL RIVER, NEW YORK

Lederle

Mercy Hospital Institute of Radiation Therapy

The Henry Schmitz Medical Group

For Appointment
Victory 2-4700, Ext. 170 or RAndolph 6-4444

Herbert E. Schmitz, M.D., *Director*
Peter A. Nelson, M.D., *General Oncology*
Henry L. Schmitz, M.D., *Internal Medicine*
Janet Towne, M.D., *Gynecology*
Robert L. Schmitz, M.D., *General Surgery*
John F. Sheehan, M.D., *Pathologist*
Charles J. Smith, M.D., *Gynecology*
Charles S. Gilbert, M.D., *Internal Medicine*
William F. Cernock, M.D., *Internal Medicine*
Fred W. Eims, *Physicist*
Miss Hilda Waterson, R.N.
Helen Hansen, *Social Service*

COMPLETE TUMOR THERAPY
Including
SUPERFICIAL X-RAY THERAPY
DEEP X-RAY THERAPY up to 1,000 K.V.
RADIUM THERAPY

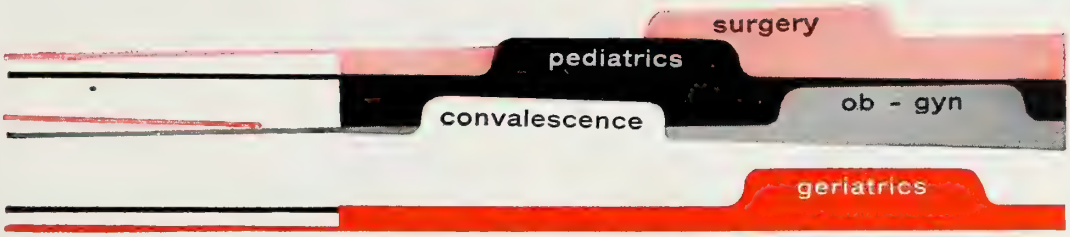
Daily Consultation at Institute
Tumor Clinic—Mercy Free Dispensary—
Tuesday at 9 a. m.
Tumor Conference — J. B. Murphy Auditorium —
Friday at 1 p. m.

Cancer in the nonsmokers

We do not want to enter into a discussion of the relative risk of nonsmokers to develop lung cancer, an analysis of which depends upon a number of unknowns and a task which has recently been well reviewed by Doll. The fact that stands out in all of these data is that a patient who is a nonsmoker has very little chance of developing lung cancer, particularly the epidermoid type. The significance of this observation is twofold. First, it should aid in our differential diagnosis of patients with lung disease, and second, it gives an index of what the lung cancer problem would mean to population groups who do not smoke. The rarity with which we see lung cancer today among nonsmokers makes us recall the experience of clinicians a few decades ago, at a time when the smoking habits were not as extensive as now, who stated that they saw lung cancer with great infrequency. It has been thought by some that clinicians and pathologists overlooked most of the lung cancers present during this time. On the basis of the present data showing the rarity with which lung cancer developed in nonsmokers, it is suggested, however, that these physicians were indeed correct in their assumption that lung cancer was uncommon in their day. These data also conform to a recent study from Iceland where lung cancer even today ranks only ninth among autopsy cancer cases—data marked in contrast to that in other parts of the Western Hemisphere. It has been pointed out by Dr. Dungal that the consumption of tobacco in Iceland in 1945 was that as seen in England in 1920. *Ernest L. Wynder, M.D., Tobacco As A Cause Of Lung Cancer. Pennsylvania M.J., Nov.* 1954.

‹ ›

The form of tuberculosis control of tomorrow is being carefully weighed in the balance today. The search for the tuberculous sick and infected must continue unabated until tuberculosis itself has been finally relegated to medical history. For the time being, we must continue to use the tools at hand as vigorously and as aggressively as practical considerations will allow. *Robert J. Anderson, M.D., NTA Transactions, May,* 1954.



LIVITAMIN® with IRON
each fluidounce contains:

Iron peptonized..... .....420 mg.
(Equiv. in elemental iron to 70 mg.)
Manganese citrate, soluble..... .....158 mg.
Thiamine hydrochloride..... ..... 10 mg.
Riboflavin..... ..... 10 mg.
Vitamin B_{12} (crystalline) .... 20 mcg.
Niacinamide..... ..... 50 mg.
Pyridoxine hydrochloride..... ..... 1 mg.
Pantothenic acid .... 5 mg.
Liver fraction 1..... ..... 2 Gm.
Rice bran extract..... ..... 1 Gm.
Inositol .... 30 mg.
Choline .... 60 mg.

. . . the reconstructive iron tonic of wide application . . .

LIVITAMIN®

WITH IRON

In debilitation, syndrome therapy instead of symptom treatment is required. Livitamin (Massengill) provides comprehensive therapy and adequate nutritional support. The appetite improves, as does the blood picture . . . improved anabolism and better digestion produce a significant syndrome reversal.

LIVITAMIN® CAPSULES with INTRINSIC FACTOR
each capsule contains:

Desiccated liver..... .....450 mg.
Ferrous sulfate..... .....130 mg.
(Equiv. to 25 mg. of elemental iron)
Thiamine hydrochloride..... ..... 3 mg.
Riboflavin..... ..... 3 mg.
Niacinamide..... ..... 10 mg.
Vitamin B_{12} .... 5 mcg.
Pyridoxine hydrochloride..... .....0.5 mg.
Calcium pantothenate..... ..... 2 mg.
Folic acid..... ..... 1 mg.
Intrinsic factor USP..... .....1/6 Unit

. . . in pernicious anemia and geriatrics . . .

LIVITAMIN®

CAPSULES WITH INTRINSIC FACTOR

Intrinsic factor is essential to provide full utilization of antianemic and nutritional factors in P. A. and many Geriatric patients. Livitamin Capsules with Intrinsic Factor (Massengill) contain intrinsic factor, U.S.P., iron and the B-complex vitamins. This integrated medication provides an optimal response in these difficult patients.

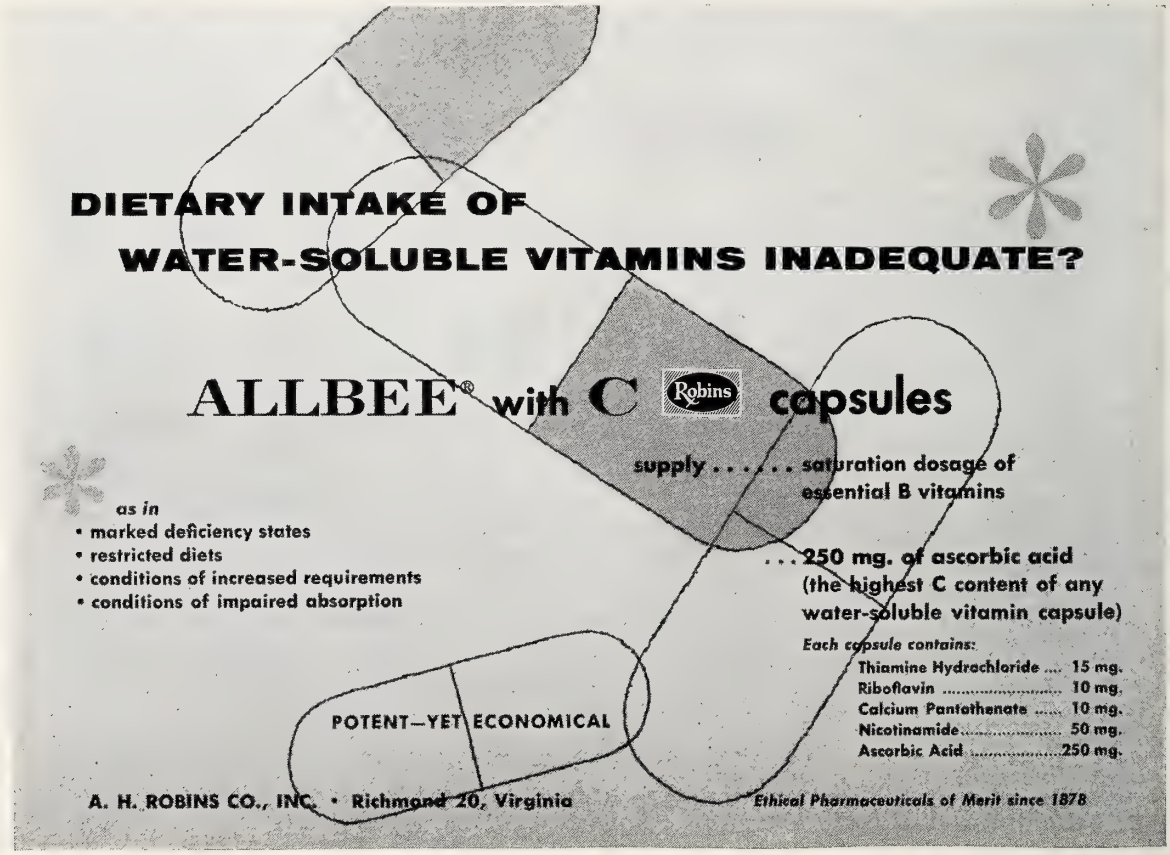
THE S. E. MASSENGILL COMPANY
BRISTOL, TENNESSEE

Cervical pathology

Perhaps 40 per cent of adult females have cervical pathology causing symptoms such as vaginal discharge, bladder irritation, backache, tuboovarian pains, nervousness, easy fatigue, excessive menses, with anemia and dyspareunia. Furthermore, cervical carcinoma usually starts in an infected cervix, and I have never seen or heard of one starting in a cervix that has been treated properly by cautery or electrocoagulation. Of course, cauterization will not cure cancer unless it is very small indeed, so I obtain a biopsy in the office on all suspicious cervices before electrical treatment. This can be done without much pain if cocaine crystals are applied beforehand, and the bleeding can be controlled by electrocoagulation. Many women who come to me with a bad cervix and a tender uterus have already had their tubes and one or both ovaries removed, and others have had the uterus removed supracervically without relief. Proper treatment of the cervix would, in many cases, have made major surgery unnecessary and would have preserved the childbearing function. *J. W. Visher, M.D., Office Gynecology. J. Indiana M. A., Aug.* 1954.

Smoking plus

If the increase in death rates from lung cancer were the only deleterious effect of cigarette smoking, then there would be reason enough to take action. The effect on the occurrence of lung cancer is bad enough in itself but it accounts for only a relatively small percentage of the total excess deaths apparently caused by cigarette smoking. In terms of number of deaths, coronary artery disease is the most important cause of death involved. The effect on deaths from cancer other than lung cancer also appears to be of some importance. We are not yet certain whether other diseases are involved. *E. Cuyler Hammond, Sc.D., Epidemiologic Studies on Smoking in Relation To Lung Cancer. Pennsylvania M.J. Nov.* 1954.



MYCIN*

HYDROCHLORIDE
Chlortetracycline HCl *Lederle*

Stands on its record!



Seven years of world-wide use . . . more than half a billion doses administered . . . millions of patients restored to normal health, many saved from death—this is the unsurpassed record of AUREOMYCIN.

AUREOMYCIN, the first extensively prescribed broad-spectrum antibiotic, must certainly rank with the major therapeutic agents available.

Thousands of published clinical trials have established its efficacy in combating many kinds of infection. Thousands of doctors give it their highest acclaim by regularly employing it in their practices.

A convenient dosage form for every medical requirement. *Lederle*

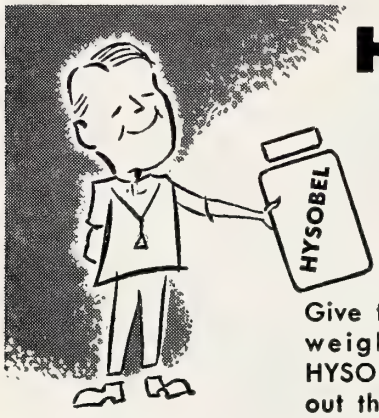
*TRADE-MARK

Keloid prevention

A series of 115 surgical cases is reported herewith in which one-half of the surgical wound was treated at the completion of surgery with a single application of hydrocortone. The healing process in the treated portions of the wounds was more benign with less evidence of postoperative inflammatory reaction in the treated segments. Eight cases of keloids developed in this series. In six, there was a complete inhibition of keloid formation in the treated segments of the wounds and in two cases, there was partial inhibition of keloidal formation. One of the eight cases was reoperated upon with excision of the scar and the same sequence of events recurred after treating the second wound in like manner. A keloid resulting from excision of a sebaceous cyst not previously treated with hydrocortone was excised. After treatment with hydrocortone ointment, this keloid has not recurred. No evidence of wound weakness, infection, or other untoward reaction occurred in this series. *Jules Leonard Whitehill, M.D., Prophylaxis of Surgical Keloids. Arizona Med., Nov.* 1954.

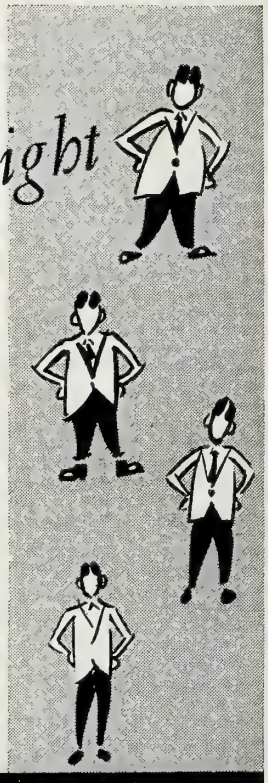
Leprosy

Since the advent of the sulfone drugs in the treatment of leprosy, a new era has dawned in the history of this ancient disease. We now have drugs that help the majority of cases. Although only a small percentage of patients at Carville show bacteriologic improvement sooner than a year after treatment has been started, clinical improvement, particularly in the skin lesions, is decidedly more rapid and a decrease in the number of demonstrable bacilli in the nasal mucosa and skin has been the rule with long continued treatment. The destructive deformities so commonly seen in the past are today being effectively prevented when treatment is started in the early stages of the disease. *Lee D. McLean, M.D., Early Diagnosis In Leprosy. J. Louisiana M. Soc., Nov.* 1954.



HYSOBEL

for those who want to lose weight



Give them the help they need to lose the weight that endangers their health. HYSOBEL. Convenient tablets with or without thyroid and phenobarbital.

HYSOBEL

d-Desoxyephedrine Hydrochloride	5 mg. (1/12 gr.)
Methylcellulose	0.15 Gm. (2½ gr.)
Thyroid	15 mg. (¼ gr.)
Phenobarbital	8 mg. (⅛ gr.)

HYSOBEL NO. 2

d-Desoxyephedrine Hydrochloride	5 mg. (1/12 gr.)
Methylcellulose	0.15 Gm. (2½ gr.)

Supplied in Bottles of 1000, 500 and 100 Tablets

THE ZEMMER CO.

Oakland Station, Pittsburgh 13, Pa.



make your llergy R$_x$ taste better

Chlor-Trimeton syrup q.s. ad

• taste appeals to young and old

compatible with commonly prescribed medications

Contains CHLOR-*TRIMETON*® Maleate
(brand of chlorprophenpyridamine maleate), 2 mg. per teaspoonful (4 cc.).

Schering

CHLOR-TRIMETON SYRUP

SCHERING

The circulation in senile dementia

The senile brain likewise often demonstrates degenerative lesions resulting from arteriosclerosis of the cerebral vessels. However, alteration of nerve elements may occur independently of vascular degeneration. There are well authenticated cases of senile dementia in the absence of any striking abnormalities of intracranial circulation. Atrophy of the ganglion cells of the cerebrum, reduction of the number of cortical cells, changes in the glia and intercellular matrix, hypertrophied astrocytes, and increased pigment content of nerve cells are characteristic of the structural alterations of the aged brain. Functionally, loss of adeptness at skilled movements, poor co-ordination, and resistance to passive movements are noted at the motor level while progressive retardation of the ability to learn, inability to form new interests, and nominal aphasia develop gradually at the cortical level — all of these changes terminating in the full blown senile psychosis. In most of these far advanced cases, both atrophy and vascular changes are responsible for the diminished function of the brain. *Robert A. Hettig, M.D., Some Physiologic Mechanisms of Aging. Texas J. Med., Aug. 1954.*

‹ ›

In spite of progressive lowering of the death rate, morbidity statistics do not permit of any complacency. It has been truly stated that the death rate from tuberculosis unaccompanied by any complementary fall in new cases is a limited and inadequate index of the prevalence of the disease in the community. Were there fewer deaths and fewer new cases the situation would give cause for greater satisfaction, for it is the number of notifications which bears a closer relationship to the incidence of the disease. *Philip Ellman, M.D., F.R.C.P., J. of Royal Institute of Pub. Health & Hyg., Aug.,* 1954.

‹ ›

Too many people are thinking of security instead of opportunity. They seem more afraid of life than death.—*James F. Byrnes*

Lederle

FOLBESYN*

Vitamins *Lederle*

A well-balanced, high-potency vitamin formula containing B-Complex and C

FOLBESYN provides B-Complex factors (including folic acid and B_{12}) and ascorbic acid in a well balanced formula. It does not contain excessive amounts of any one factor.

FOLBESYN Parenteral may be administered intramuscularly, or it may be added to various hospital intravenous solutions. It is useful for preoperative and postoperative treatment and during convalescence.

Dosage: 2 cc. daily. Each 2 cc. provides:

Thiamine HCl (B_1)	10 mg.
Sodium Pantothenate	10 mg.
Niacinamide	50 mg.
Riboflavin (B_2)	10 mg.
Pyridoxine HCl (B_6)	5 mg.
Ascorbic Acid (C)	300 mg.
Vitamin B_{12}	15 micrograms
Folic Acid	3 mg.

FOLBESYN is also available in tablet form, ideal for supplementing the parenteral dose.

LEDERLE LABORATORIES DIVISION AMERICAN Cyanamid COMPANY Pearl River, New York

*REG. U.S. PAT. OFF.

RHINALGAN®

NASAL DECONGESTANT

Uniformly *Safe!* FOR INFANTS • CHILDREN ADULTS AND AGED

DOES NOT CONTAIN ANY ANTIBIOTIC

Does not affect

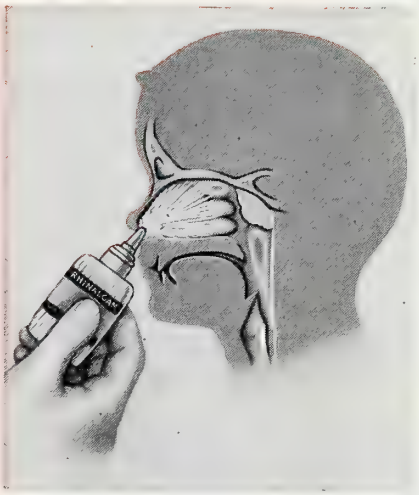
BLOODPRESSURE
RESPIRATION
CENTRAL NERVOUS SYSTEM

ENTIRELY Safe! in

CARDIAC—DIABETIC
PREGNANCY—THYROID
AND HYPERTENSION CASES

Authoritative Proof sent on request.

COMPLETELY FREE OF SIDE-EFFECTS... no cumulative action... no overdosage problem... non-toxic.



ANTIBACTERIAL WITHOUT ANTIBIOTICS!

For *Safety!* USE RHINALGAN

NOW Modified Formula assures PLEASANT, PALATABLE TASTE!

FORMULA: Desoxyephedrine Saccharinate 0.05% w/v in an isotonic aqueous solution with 0.02% Laurylammonium saccharin. Flavored. pH 6.4.

Available on YOUR prescription only!

Reference to RHINALGAN:

1. Van Alyea, O. E., and Donnelly, W. A.: E.E.N.&T. Monthly, 31, Nov. 1952.
2. Fox, S. L.: AMA Arch. Otolaryn., 53, 607-609, 1951.
3. Molomut, N., and Harber, A.: N.Y. Phys., 34, 14-18, 1950.
4. Lett, J. E., (Lt. Col. MC-USAF) Research Report, Dept. Otolaryn., USAF School Aviat. Med., 1952.
5. Hamilton, W. F., and Turnbull, F. M.: J. Amer. Pharm. Ass'n., 7, 378-382, 1950.
6. Browd, Victor L.: Rehabilitation of Hearing, 1950.
7. Kugelmass, I. Newton: Handbook of the Common Acute Infectious Diseases, 1949.

NEW O TOS-MO-SAN—A specific in Suppurative Ear Infections (Acute or Chronic).

AURALGAN—After 40 years STILL the auralgesic and decongestant.

RECTALGAN-Liquid—For symptomatic relief in: Hemorrhoids, Pruritus, Perineal Suturing

DOHO CHEMICAL CORP., 100 Varick Street, New York 13, N. Y.

Do You Know ? ? ?

THE SPECIAL DISABILITY PLAN

AVAILABLE TO MEMBERS OF

THE ILLINOIS STATE MEDICAL SOCIETY

Provides Benefits up to . .

$5000. ACCIDENTAL DEATH AND DISMEMBERMENT

$100. PER WEEK FOR TOTAL LOSS OF TIME as the result of either Sickness or Accident.
$15. DAILY HOSPITALIZATION for up to 90 days as the result of either Sickness or Accident.

Plus . . .

Optional 5 Year Sickness Coverage
No reduction in benefits because of other insurance
Full benefits to age 70 at same cost
(All Benefits Subject to Provisions of the Policy)

FOR ALL THE FACTS - - -
Write or Telephone

PARKER, ALESHIRE & COMPANY

175 W. JACKSON BOULEVARD

Chicago 4, Ill. **WAbash 2-1011**

DOCTOR! you will approve the 3C's
Comfort, Cleanliness, Convenience



at Bee Dozier's 3 Sanitariums for

Aged, Chronic, Senile, Convalescent Patients.

Hickory Hill,
Maple Hill, *Palatine*

Charming, healthful rural locations conveniently situated, 24 hour care by trained nurses and orderlies, tempting food and supervised diets all contribute to your patient's well-being or recovery. 18 years of experience.

ONE rate covers EVERYTHING. There are NO extras.

Bee Dozier invites your inspection. Write Box 288, Lake Zurich, Ill., or Phone 4661

What are radio-isotopes?

The name, radio-isotopes, is commonly applied to the artificially produced elements which spontaneously disintegrate and in doing so, give off alpha, beta, or gamma rays. The medical profession has been schooled in the use of similar substances since the discovery of radium. The behavior of the artificial radio-isotopes is the same as radium; but each has its own scheme of disintegration, type of particle or ray given off, energy content, and so on. Knowledge of the physical characteristics of the radio-isotopes used is essential. A consultant physicist may be necessary to set up technics, advise on radioactive waste disposal, check equipment, and provide liaison with the medical aspects of the enormous physics research program in atomic energy. *Robert J. Gross, M.D., Private Practice Use Of Radio-Isotopes. J. Med. Soc. New Jersey, Nov.* 1954.

‹ ›

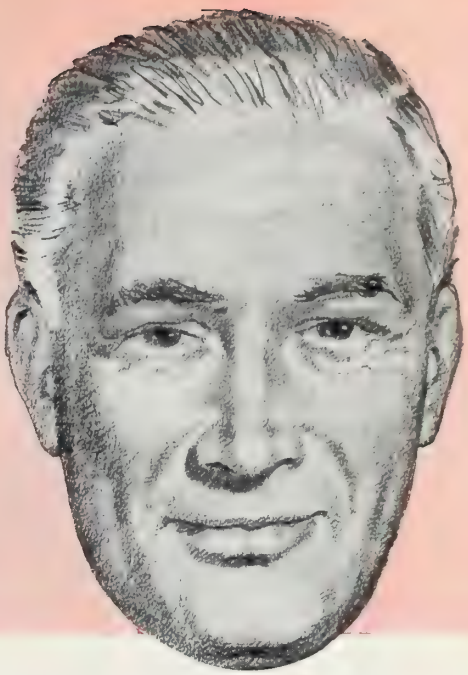
The finger tip

Of all the finger tip injuries, perhaps the most common one is partial amputation of the finger tip. Actually, the tip of the finger may be sliced off by means of carving knives, sharp tools, and various types of mechanical gadgets. In many instances, the fat pad is spared, and only the thick epithelial covering has been removed from the anterior space. In such an injury of the finger tip the wound should be properly treated as outlined and primary closure should be done. I believe that the equivalent of a large pinch graft or thick split-thickness graft easily closes the wound, prevents infection, and above everything else, results in a healing process with minimal scarring and tenderness in this region. The greatest pitfall is to treat this wound as an open wound. *Vinton E. Siler, M.D., Injuries Of the Hand. J. Kentucky M.A., Nov.* 1954.

‹ ›

Prayer is a force as real as terrestrial gravity. As a physician, I have seen men, after all other therapy had failed, lifted out of disease and melancholy by the serene effort of prayer. Only in prayer do we achieve that complete and harmonious assembly of body, mind, and spirit which gives the frail human reed its unshakeable strength.—*Dr. Alexis Carrel*

In this... "the Commonest Disease of Civilized Man"



- In hypertension, management can now be started in the earliest stages . . . to retard progression, with the goal of prolonging useful life.

- Fully one half of all cases of mild, labile hypertension can be controlled with simple Rauwiloid therapy.

- Rauwiloid accomplishes what mere sedation cannot . . . the patient is spared the reaction to tension situations . . . without somnolence, without clouded sensorium, without change in alertness.

- The feeling of well-being engendered by Rauwiloid may become manifest as soon as 24 to 48 hours after the first dose. Its antihypertensive effect becomes apparent in two to three weeks.

- In the face of tension-producing stimuli, Rauwiloid, through its sedative and bradycrotic properties, provides tranquil equanimity.

- Its dosage schedule is uncomplicated, definite, easy to follow: Merely 2 tablets at bedtime. For maintenance, 1 tablet usually suffices. No contraindications.

Rauwiloid® *First Thought IN HYPERTENSION*

Riker LABORATORIES, INC., LOS ANGELES 48, CALIF.

THE
MEDICAL PROTECTIVE
COMPANY
FORT WAYNE, INDIANA

the doctor's most secure source of security

PROFESSIONAL PROTECTION
EXCLUSIVELY
SINCE 1899

CHICAGO Office:
T. J. Hoehn, E. M. Breier and
W. R. Clouston, Representatives,
1142-44 Marshall Field Annex Building,
Telephone State 2-0990

SPRINGFIELD Office:
F. A. Seeman, Representative,
Telephone Springfield 4-2251



LINCOLNVIEW
Hospital and Sanitarium
Springfield, Illinois
8th & Capitol

Albert P. Ludin, M. D., Medical Director

MENTAL-ALCOHOLIC-ADDICTED

Rapid Intensive Treatment

Registered A.M.A. Licensed State of Illinois

Phone 2-3303

BELLEVUE PLACE
For
NERVOUS and MENTAL
DISEASES

★

Edward Ross, M.D., Medical Director
BATAVIA
ILLINOIS
PHONE
BATAVIA 1520

Undescended testicles

The causes of cryptorchidism may be listed as (1) maldevelopment of the epididymis with failure of proper attachment at the lower pole of the testis, (2) failure of proper attachment and development of the gubernaculum due to the epididymal maldevelopment, (3) poor development of the cremaster, (4) defect of the inguinal canal with hernia, (5) closure of the scrotal ring, (6) failure of development of the scrotum, and (7) lack of hormonal stimulation. Hormone therapy, by administration of antuitrin "S" or testosterone, is contraindicated in infants and young children because of failures and because of the untoward effects of advancement of puberty. Hormones cause descent only of those testes that would normally descend at puberty and may be used at or just before the onset of puberty. Indications for surgery are (1) the presence of demonstrable hernia in infants, (2) abdominal cryptorchidism, and (3) failure of hormone therapy at or just before puberty in inguinal cryptorchidism. Surgery is advised at an earlier age (under 6 years of age) than heretofore deemed necessary in order to improve our results as far as fertility is concerned. *Lloyd G. Lewis, M.D., Cryptorchidism. New York J. Med., Nov.* 15, 1954.

‹ ›

They need physicians

Every community or national program for the control of poliomyelitis, tuberculosis, heart disease, cancer, or neurological and mental diseases depends for its success upon the availability of well trained physicians. Programs for maternal and infant health, school health programs, and health education all require the guidance and services of physicians. Industrial hygiene, rural health, labor union health programs, rehabilitation of the physically handicapped, and every field of preventive medicine depend for their success upon physicians, and in turn upon the medical schools who train physicians—the sole source of physicians. *Walter A. Bloedorn. Public Relations In The School Of Medicine. J. Med. Educ., Nov.* 1954.

‹ ›

There are three things to aim at in public speaking; first, to get into your subject, then to get your subject into yourself, and, lastly, to get your subject into your hearers.—*Gregg*

FAIRVIEW
Sanitarium

DEVOTED TO THE ACTIVE TREATMENT OF

MENTAL and NERVOUS DISORDERS

Specializing in Psycho-Therapy, and Physiological therapies including:

- **Electro-Shock**
- **Electro-Narcosis**
- **Insulin Shock**
- **Carbon Dioxide Therapy**

Out Patient Shock Therapy Available

ALCOHOLISM Treated by Comprehensive Medical-Psychiatric Methods.

2828 S. PRAIRIE AVENUE, CHICAGO 16 J. DENNIS FREUND, M. D., Medical Director

Phone Victory 2-1650 **Registered by the American Medical Assn.**

New drug law

For a century at least, a physician who desired to limit the supply of a drug to a patient indicated that fact by a notation on the prescription. The pharmacist obeyed that request without question. The absence of a limiting notation on the prescription was universally understood to mean that permission to refill the prescription upon the patient's request would be honored by the pharmacist, within the bounds of professional ethics and obligations. Never has pharmacy tried to sell prescription drugs except upon the request of the doctor of the patient. Drugs never have been merchandisable items in pharmacy. These pharmacy practices are so inviolable that even today most physicians still adhere to the old practice of prescription writing and intent; but the federal law has placed a new and directly opposite meaning on a prescription bearing no notation concerning refilling. Today such a prescription which calls for any important drug, and some not so important, is not refillable except upon specific authorization of the prescriber. *Joseph H. Goodness, The Profession of Pharmacy and The Food, Drug, and Cosmetic Laws. South Dakota Med. and Phar. Nov.* 1954.

‹ ›

Steady elimination of chronic infectious illness has not only saved lives outright, but also has helped extend the average age of the population, so that physicians deal much more frequently than formerly with the ailments of old people, and society must construct appropriate institutions for their care. *Esmond R. Long, M. D., Bulletin of History of Medicine, July-Aug.,* 1954.

‹ ›

No one knows where he who invented the plow was born, nor where he died; yet he has done more for humanity than the whole race of heroes who have drenched the earth with blood and whose deeds have been handed down with a precision proportionate only to the mischief they wrought.—*Colton*

in whooping cough

ELIXIR BROMAURATE

GIVES EXCELLENT RESULTS

Cuts short the period of illness and relieves the distressing spasmodic cough. Also valuable in Bronchitis and Bronchial Asthma.

In four-ounce original bottles. A teaspoonful every 3 to 4 hours.

Prescribed by Thousands of Doctors

GOLD PHARMACAL CO. **NEW YORK CITY**

The NORBURY SANATORIUM

JACKSONVILLE, ILLINOIS — INCORPORATED and LICENSED

For the Treatment of Nervous and Mental Disorders

FRANK GARM NORBURY, M.D., Medical Director
HENRY A. DOLLEAR, M.D., Superintendent
FRANK B. NORBURY, M.D., Associate Physician

Address Communications — THE NORBURY SANATORIUM, Jacksonville, Illinois

Encouraging!

In general, a number of important intellectual changes occur with aging. There is some evidence that persons of higher intelligence and those who make constant use of their intellectual capacities preserve these functions better than do those who make little use of them. Loss of memory for recent events is common as one grows older, but there often is excellent memory for the remote past. Intellectual capacities are ordinarily lower, as determined by standard intelligence tests, but this has to do largely with speed of reaction rather than actual ability to deal with problems. Scores in certain tests such as that of vocabulary show little falling off, and may even increase in the 50s and 60s. The observation that older persons learn less quickly than do younger ones is partially explained by lack of motivation. Margaret Mead observed that the Balinese, most of whom believe in reincarnation, retain ability to learn new and complicated tasks which will supposedly help them in their new life. The older person often may possess better judgment, and his breadth of view and depth of understanding may make him more valuable for many positions. *Karl M. Bowman, M.D., Personality Development in Aging Adults. Geriatrics, Dec.* 1954.

‹ ›

Measles plus

Measles outbreaks in the tropics are of equal moment; over half of Gilbert Island inhabitants came down with measles when the disease was introduced from Fiji in 1936. Ten years later, in British Islands of the South Pacific, nearly all children under 16 years of age got measles, with 1,000 deaths among 15,000 to 20,000 cases. Co-existent malaria, dysentery, and pneumonia contributed to the high fatality. Guam had an epidemic of less severe proportions in 1948. *Frank L. Babbott, M.D. and John E. Gordon, M.D. Modern Measles. Amer. J. Med. Sciences, Sept.* 1954.

‹ ›

All work in education and leadership training is a part of health education, particularly if mental health aspects are included. Magda Kelber, M. D., European Conference on Health Education of the Public, London, England, April 10-18, 1953.

North Shore Health Resort

on the shores of Lake Michigan
WINNETKA, ILLINOIS

NERVOUS and MENTAL DISORDERS
ALCOHOLISM and DRUG ADDICTION

Modern Methods of Treatment
MODERATE RATES

Established 1901 — *Fully Approved by the*
Licensed by State of Illinois — *American College of Surgeons*

SAMUEL LIEBMAN, M.S., M.D.
Medical Director

225 Sheridan Road — Winnetka 6-0211

HydroCortone®

(HYDROCORTISONE, MERCK)

In rheumatic fever early therapy may prevent residual cardiac damage[1]

MAJOR ADVANTAGES: Intense anti-inflammatory action. Prompt suppression of symptoms. Lifesaving therapy in some instances.



Most clinicians agree that HYDROCORTONE like cortisone produces prompt suppression of the extra cardiac manifestations of rheumatic fever. Agreement is also general that adequate hormonal therapy favorably influences pericarditis, prolonged PR interval and congestive failure (when sodium intake is restricted). While less unequivocal there is considerable evidence that adrenocortical therapy also suppresses tachycardia, gallop rhythm and overactivity.[2]

The main point in question remains the ability of HYDROCORTONE or CORTONE to prevent valvulitis. On this score, Kroop[1] in a recent study of 56 patients with rheumatic fever concludes "A two-year follow-up of patients who had sustained initial attacks of carditis indicates that early treatment with large doses may prevent residual cardiac damage." This conclusion is further supported by a recent review[3] which states ". . . many of the reported poor responses of rheumatic fever to treatment occurred in cases in which either very small doses of the hormones were used or treatment was continued for only a short period of time."

SUPPLIED: HYDROCORTONE Tablets: 20 mg., bottles of 25, 100 and 500 tablets; 10 mg., bottles of 50, 100 and 500 tablets; 5 mg. bottles of 50 tablets.

SHARP & DOHME

PHILADELPHIA 1, PA.
DIVISION OF MERCK & CO., INC.

REFERENCES: 1. Kroop, I. G., *N. Y. State J. Med.* **54**:2699, Oct. 1, 1954. 2. Heffer, E. T. *et al.*, *J. Pediatrics* **44**:630, June 1954. 3. Massell, B. F., *New England J. Med.* **251**:263, Aug. 12, 1954.

A new theory

The vertebral artery, as no other artery in the human body, has to traverse six relatively small foramina, the foramina transversaria in the cervical verterbrae, in order to reach its goal within the cranium. It was logical to assume that in certain cases of hypertrophic osteosis of the cervical spine, these foramina could become involved, producing an embarrassment of the blood flow within this artery. It was felt that if there were compression or embarrassment of this artery which carries the sole blood supply for the medulla and upper cervical cord, lesions similar to those seen in amyotrophic lateral sclerosis could well be produced. *Otto L. Bendheim, M.D., The Possible Role of The Vertebral Artery in Amyotrophic Lateral Sclerosis. Arizona Med., Dec.* 1954.

‹ ›

The young man who has the combination of the learning of books with the learning which comes of doing things with the hands need not worry about getting along in the world today, or at any time.—*William S. Knudsen*

Ghandi's calm

Then, out of the mists of Indian oblivion, arose Rauwolfia. For hundreds of years, the powdered root of this lovely shrub with its bright green leaves and pinkish-white flowers had been hawked in the bazaars as a cure for lunacy, diarrhea, and snakebite. It is reliably reported that Mahatma Ghandi, by chewing on Rauwolfia root, gained the calm that drove the British so wild they went away without a struggle, giving India back to the Indians. *Paul De Kruif, Rauwolfia. Minnesota Med., Dec.* 1954.

‹ ›

Routine chest roentgenograms for patients admitted to the hospital are more productive than a routine survey on a general population of essentially normal persons. Figures vary tremendously according to the type of hospital, the type of patients admitted, and the care with which the roentgenograms are studied and reported by the roentgenologist. Morris H. Levine, M.D., and Stanley Crosbie, M.D., J.A.M.M.A., Sept. 18, 1954.



Diamox*

ACETAZOLEAMIDE LEDERLE

NOW ACCEPTED FOR USE IN

EPILEPSY[1]

Recent clinical trials show that DIAMOX suppresses both the frequency and severity of epileptic seizures. DIAMOX appears to produce a relative acidosis, in a manner similar to the ketogenic diet, and may also have a direct effect on nerve tissue. No direct sedative action is apparent.

GLAUCOMA[2]

Oral administration of DIAMOX is followed by significant reduction in intraocular pressure in acute glaucoma. Experimental evidence indicates decreased secretion of aqueous humor. DIAMOX also appears to enhance the action of commonly employed miotics.

CARDIAC EDEMA

Now the most widely prescribed drug of its type, DIAMOX has been immediately accepted by clinicians because it is an effective, safe and convenient *oral* diuretic.

Available in 250 mg. tablets and 500 mg. ampuls for intravenous use.

1. MERLIS, S.: Diamox: A Carbonic Anhydrase Inhibitor—Its Use in Epilepsy. Neurology. 4:11, 863-866 November 1954.

2. BECKER, B.: Decrease in Intraocular Pressure in Man by a Carbonic Anhydrase Inhibitor, Diamox. Am. J. Ophth. 37:1, 13-15 January 1954.

LEDERLE LABORATORIES DIVISION *AMERICAN Cyanamid COMPANY*
PEARL RIVER, NEW YORK

Lederle

*REG. U.S. PAT. OFF



MARY POGUE SCHOOL, Inc.

Complete facilities for training retarded and epileptic children educationally and socially. Pupils per teacher strictly limited. Excellent educational, physical and occupational therapy programs.

Recreational facilities include riding, group games, selected movies under competent supervision.

Separate buildings for boys and girls under 24 hour supervision of skilled personnel.

Catalog on request

G. H. Marquardt, M.D. — *Medical Director*

Barclay J. MacGregor — *Registrar*

33 GENEVA ROAD, WHEATON, ILLINOIS

(near Chicago)

Classified Ads

RATES FOR CLASSIFIED ADVERTISEMENTS—For 30 words or less: 1 insertion, $3.00; 3 insertions, $8.00; 6 insertions, $14.00; 12 insertions, $24.00; from 30 to 50 words: 1 insertion, $4.00; 3 insertions, $10.50; 6 insertions, $20.00; 12 insertions, $30.00. Extra words: 1 insertion 10c each; 3 insertions, 25c each; 6 insertions, 40c each; 12 insertions, 50c each. A fee of 25c is charged for those advertisers who have answers sent care of the Journal. Cash in advance must accompany copy.

WANTED: Cardiologist wishes to interpret electro-cardiograms for private physicians, indust, surgeons, group clinics, etc., in his office. Reports by return mail. Box 223, Ill. Med. Jl. 185 N. Wabash Ave. Chicago 1, Ill.

WANTED: Physician, 40-55, as staff member of active private sanitarium for diseases of addiction. Permanent, full-time, salaried position for qualified physician preferably with a background of general practice. Please apply by letter to James I. Oughton, administrator, The Keeley Institute, Dwight, Ill. 7/55

FOR SALE: Standard Model-D tilting, shockproof, radiographic fluoroscopic Bucky table. Shockproof tube. Also tube under table. Rail tubestand. 100-100 Standard valve x-ray. Plate changer, stereoscope, darkroom. Many access. $2000.00. Box 224. Ill. Med. Jl. 185 N. Wabash, Chi. 2.

The femoral hernia

Femoral hernias should be operated upon as soon as possible after they appear. About 40 per cent of femoral hernias become strangulated sooner or later and the mortality rate is high in strangulated femoral hernias because gangrene quickly ensues due to rigidity of the environs of the femoral canal. *Amos R. Koontz, M.D., The Hernia Problem. Maryland M.J., Oct.* 1954.

‹ ›

The steady reduction in mortality rates of tuberculosis is, in no small measure, due to social advances and to the great achievement of preventive no less than therapeutic measures. Phillip Ellman, M.D., J. of Royal Institute of Pub. Health & Hygiene, August, 1954.

THUMBSUCKING

since infancy caused this malocclusion.



THUM TRADE MARK

THUM broke the habit and teeth returned to normal position.

ACCEPTED FOR ADVERTISING IN PUBLICATIONS OF THE AMERICAN MEDICAL ASSOCIATION

Get Thum at your druggist or surgical dealer. Prescribed by physicians for over 20 years.

Anatomy is easy

More than 700,000 species of insects have now been described and doubly named — just fancy a vocabulary (international) with a million nouns — and that is not the whole story. If the estimate is correct that we have identified less than 20 per cent of the species now existing, we might as well give up all hope of obtaining an essentially complete census. Perhaps biologists should follow the example of the astronomers, who are also overwhelmed with numbers, and resort to intensive and hopefully complete investigation and description in small selected areas only, while still doing further superficial work on any region that looks particularly interesting or profitable because of localized peculiarities. *Harlow Shapley's review of Classification of Insects by Brues, Melander, and Carpenter. Amer. Scientist, Jan.* 1955.

THE KEELEY INSTITUTE

DWIGHT, ILLINOIS

Treating alcoholism and other problems of addiction.

REGISTERED BY THE AMERICAN MEDICAL ASSOCIATION—
MEMBER AMERICAN HOSPITAL ASSOCIATION.

Table of Contents

May, 1955
Vol. 107, No. 5

PROGRAM ONE HUNDRED FIFTEENTH ANNUAL MEETING ILLINOIS STATE MEDICAL SOCIETY 247

ORIGINAL ARTICLES

Symposium on the Uses and Abuses of Chemotherapy and Antibiotic Agents For Infections in Children.
- Uncomplicated Upper Respiratory Infections in Children and the Promiscuous Use of Chemotherapeutic and Antibiotic Agents. L. M. Hardy, M.D., Chicago 217
- A Controlled Study in the Uses of Chemotherapeutic and Antibiotic Agents in Uncomplicated Upper Respiratory Infections in Children. Howard S. Traisman, M.D., Chicago 221
- The Rational Use of Antibiotics and Sulfonamides in the Treatment of Respiratory Tract Infections. Paul P. Pierce, M.D., Alton 225
- The Failure of Antibiotics and Chemotherapy in Otolaryngology. James S. Walker, M.D., Urbana 231

Potassium-Sodium Relationship in Protein Metabolism. Paul R. Cannon, M.D., Chicago 234
Emergency Tracheal and Bronchial Conditions. Stanley H. Bear, M.D., Major USAF (MC) 236
Recognition and Diagnosis of Diabetes Mellitus. Lucille A. Sprenger, M.D., Peoria 240
The General Practitioner, L. H. Johnson, M.D., Casey 245

EDITORIALS

The Annual Secretaries' Conference 267
Drug reactions 268
Reawakening of interest in hemophilia 268
J. Mather Pfeiffenberger had an interesting trip 269
Medical reservists to receive credits for attendance at annual AMA meeting 270
Presidential inaugural ceremony to be broadcast 270

MEDICAL ECONOMICS

Medical Charities. Roland R. Cross, Jr., M.D., Chicago 271

CORRESPONDENCE

Annual Meeting of the Illinois Obstetrical and Gynecological Society 274
Comprehensive course in industrial medicine 274
U. of I. alumni meeting 274
Emge will deliver Bacon Lecture 274
Ninth lecture on "Treatment in Psychiatry" 275
Clinics for crippled children listed for June 275
Ophthalmologists of the Americas to meet in Santiago, Chile in 1956 275
American proctologic society annual meeting 276

NEWS OF THE STATE 277

Editor
Harold M. Camp
Monmouth, Illinois

Associate Editor
Theodore Van Dellen
Chicago, Illinois

Business Manager and Managing Editor
Mr. L. E. Malley
185 N. Wabash Avenue
Chicago 1, Illinois

Business Office
185 N. Wabash Avenue
Chicago 1, Illinois

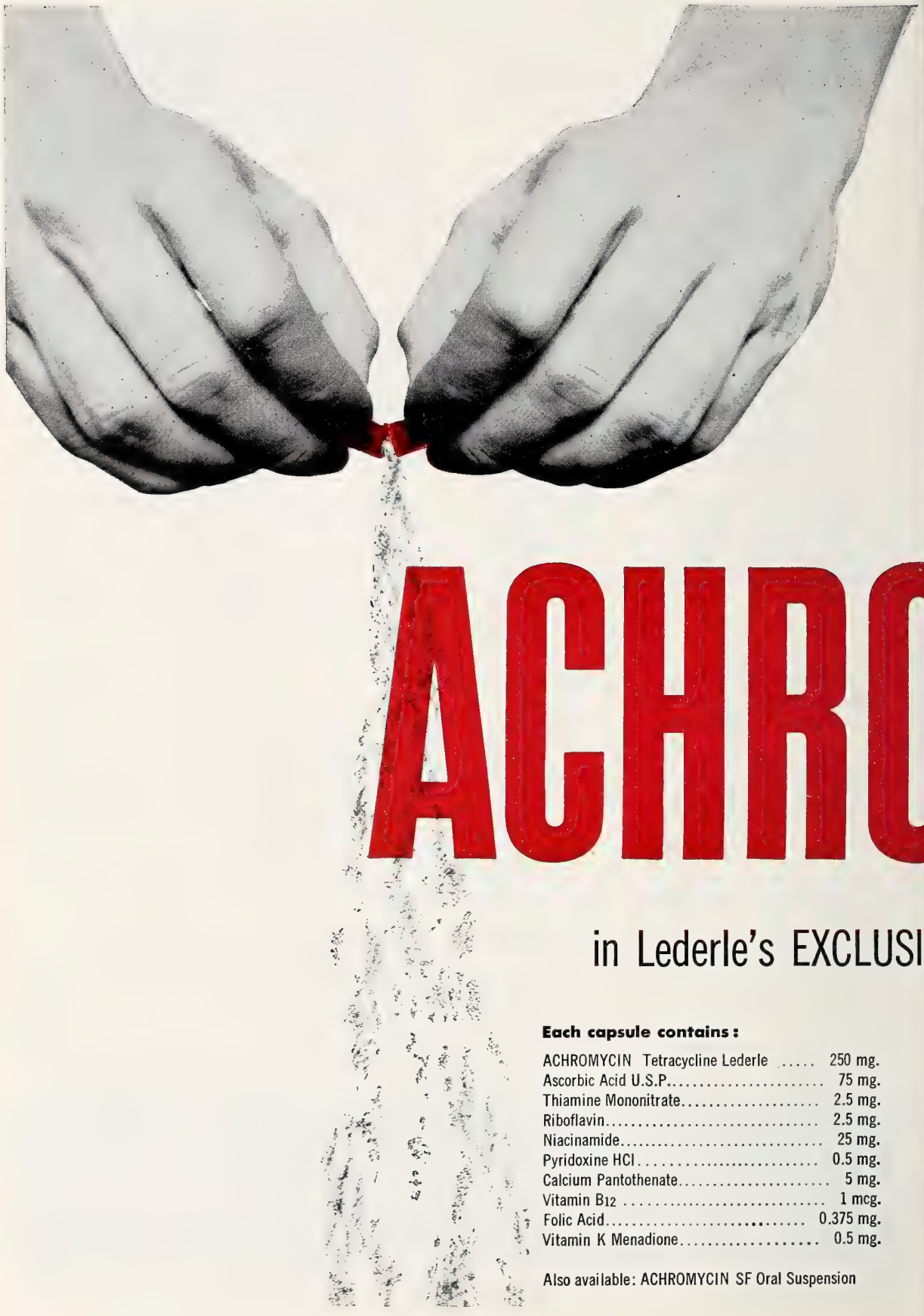
Editorial Office
Medical Arts Building
Monmouth, Illinois

Send original articles and membership correspondence to Harold M. Camp, Monmouth, Ill.

Send changes in the mailing list to Managing Editor, 185 N. Wabash Ave., Chicago 1, Ill.

Subscription price of this JOURNAL to persons not members of the Illinois State Medical Society is $4.00 per year, in advance, postage prepaid, for the United States, Cuba, Puerto Rico, Philippine Islands, Hawaiian Islands and Mexico. $5.00 per year for all foreign countries included in the postal union. Canada, $4.50. Single current copies 50 cents. By mail, 60 cents.

Entered as Second-Class Matter November 12, 1952 at the Post Office, Mendota, Illinois, under the Act of March 8, 1879. Acceptance for mailing at special rate postage provided for in section 1102, Act of October 8, 1917, authorized July 15, 1918. Printed monthly by The Wayside Press, Mendota, Illinois. Office of Publication, 1501 W. Washington Road, Mendota, Illinois. POSTMASTER — Return underliverable copies under form 3579 to 1501 W. Washington Road, Mendota, Illinois.



ACHRO

in Lederle's EXCLUSIV

Each capsule contains:

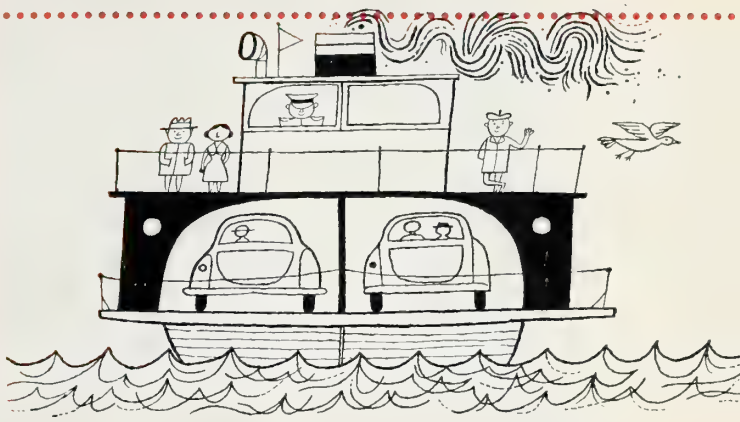
ACHROMYCIN Tetracycline Lederle	250 mg.
Ascorbic Acid U.S.P.	75 mg.
Thiamine Mononitrate	2.5 mg.
Riboflavin	2.5 mg.
Niacinamide	25 mg.
Pyridoxine HCl	0.5 mg.
Calcium Pantothenate	5 mg.
Vitamin B_{12}	1 mcg.
Folic Acid	0.375 mg.
Vitamin K Menadione	0.5 mg.

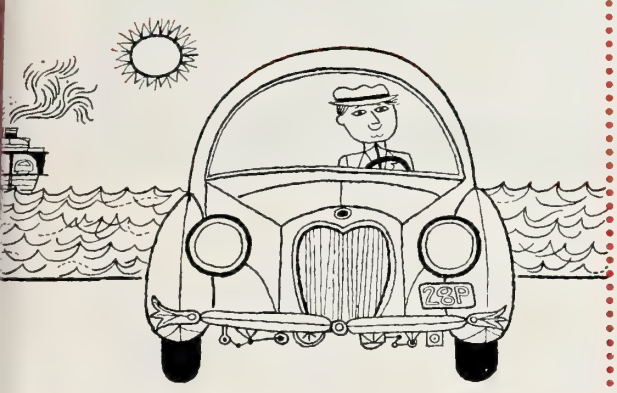
Also available: ACHROMYCIN SF Oral Suspension

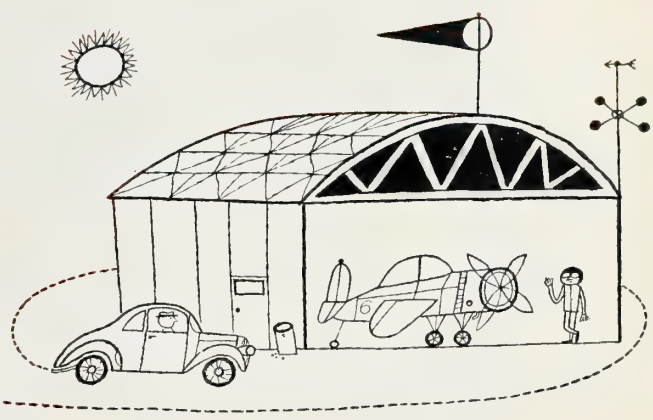












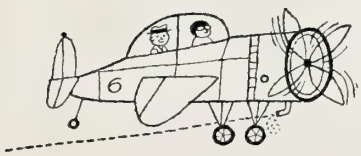
. . . a comfortable voyage now assured with **Bonamine*** HCl

BRAND OF MECLIZINE HYDROCHLORIDE

. . . the first motion-sickness preventive effective in a single daily dose

. . . prevents or relieves motion sickness due to all forms of travel

. . . available on prescription only for full physician supervision



Bonamine *is also useful in controlling the nausea, vomiting and vertigo associated with morning sickness of pregnancy, vestibular and labyrinthine disturbances, cerebral arteriosclerosis, radiation therapy and Menière's syndrome.*

Supplied in scored, tasteless 25 mg. tablets, boxes of 8 and bottles of 100 and 500.

*TRADEMARK

PFIZER LABORATORIES
Division, Chas. Pfizer & Co., Inc.

Pfizer

COUNTY MEDICAL SOCIETY OFFICERS

This list is corrected in accordance with the best information obtainable at the date of going to press. County Secretaries are requested to notify The Journal of any changes or errors.

COUNTY SOCIETY	PRESIDENT	SECRETARY
Adams	Ted Stebbins, 1416 Maine Street, Quincy	Newton DuPuy, 1101 Maine St., Quincy
Alexander	Howard Stuckey, Cairo	Paul S. Baur, Cairo
Bond	William L. Hall, Greenville	Boyd McCracken, Greenville
Boone	Bernard F. O'Malley, 103½ Logan Ave., Belvidere	Everett F. Dettmann, 519 South State St., Belvidere
Bureau	Kent McQueen, Tiskilwa	Raymond E. Davis, 128 N. Spaulding St., Spring Valley
Carroll	Mac H. Seyfarth, Lanark	L. B. Hussey, Savanna
Cass	Robert A. Spencer, 117 West 4th St., Beardstown	A. G. Hyde, 507 Washington St., Beardstown
Champaign	Carl Greenstein, 207 W. University, Champaign	Leo L. Roseman, 631 East Green St., Champaign
Chicago	Frank H. Fowler, 86 East Randolph Street, Chicago	Norris J. Heckel, 86 E. Randolph St., Chicago
BRANCH OFFICERS		
Aux Plaines	Charles E. Franklin, 715 Lake St., Oak Park	George J. Kidera, 21 Northgate Rd., Riverside
Calumet	Emerson McVey, 11254 S. Mich. Ave., 28	Roland Olsson, 29 W. 111th St., 28
Douglas Park	Norman M. Frank, 4 S. Prospect, Clarendon Hills	Bryan Carder, 2125 Clinton Ave., Berwyn
Englewood	Fred J. Stucker, 6908 S. Halsted St., 21	William Nainis, 657 W. 79th Street, 20
North Suburban	Winston H. Tucker, P.O. Box 870, Evanston	Robert L. Craig, 636 Church St., Evanston
Irving Park Suburban	George L. Pastnack, 1918 Woodland Ave., Park Ridge	Fred A. Tworoger, 4753 Broadway, 40
Jackson Park	Hilger P. Jenkins, 826 E. 61st St., 37	Andrew J. Brislen, 6060 S. Drexel Blvd., 37
North Shore	Ralph E. Dolkart, 670 N. Mich. Ave., 11	J. Ernest Breed, 59 E. Madison Street, 2
North Side	Granville Bennett, 1853 W. Polk St., 12	Caesar Portes, 25 E. Washington St., 2
Northwest	Nathaniel J. Kupferberg, 3315 Milwaukee Ave., 41	Henry Hanelin, 25 E. Washington St., 2
South Chicago	John J. Brosnan, 7939 S. Western Ave., 20	Carl Werelius, 2376 E. 71st Street, 49
South Side	Charles W. Bibb, 417 E. 47th St., 15	Quentin Young, 1525 E. 53rd Street, 15
Southern Cook County	Gilbert Towle, 1028 Scott Ave., Chicago Heights	R. C. Aiken, 13000 S. Maple Ave., Blue Island
Stock Yards	William Patejdl, 5000 S. Ashland Ave., 9	Glenn A. Burckart, 1514 W. 74th St., 36
West Side	Nicholas J. Balsamo, 6429 W. North Ave., Oak Park	Ted LeBoy, 5063 W. Madison St., 44
Christian	W. S. Miller, Assumption	E. C. Bartlesmeyer, Taylorville
Clark	Julian S. Lorenz, 401 E. Wash. St., Casey	Eugene P. Johnson, 627 W. Main St., Casey
Clay	E. D. Foss, Flora	L. L. Hutchens, Flora
Clinton	R. D. Roane, Carlyle	J. Q. Roane, Carlyle
Coles Cumberland	William Hite, Charleston	Stanley W. Thiel, Mattoon
Crawford	M. D. Miodus, Oblong	J. W. Long, Robinson
DeKalb	E. J. Fenwick, Sycamore	Carl E. Clark, Sycamore
DeWitt	E. M. Thompson, Clinton	John Sellett, Farmer City
Douglas	James Taylor, Villa Grove	Grant A. Jones, Arthur
DuPage	D. D. Jamison, Medical Dental Center, Wheaton	Samuel K. Lewis, 235 Mich. St., Elmhurst
Edgar	P. E. Fleener, Paris	W. Hoeffding, Paris
Edwards	H. L. Schaefer, West Salem	Andrew Krajec, West Salem
Effingham	Richard Hartman, Effingham	Henry J. Poterucha, Effingham
Fayette	George A. Stanbery, Vandalia	Edward A. Kuehn, Vandalia
Ford	P. W. Sunderland, Gibson City	R. N. Hutchison, Gibson City
Franklin	James T. Donosky, Wood Building, Benton	W. J. Swinney, Benton
Fulton	W. I. Taylor, Canton	O. W. Wood, Ipava
Gallatin	Joseph Bryant, Ridgway	J. A. Kirby, New Haven
Greene	A. K. Baldwin, Carrollton	Paul A. Dailey, 525 So. Main St., Carrollton
Hancock	Harold J. Collins, LaHarpe	Robert Sexton, Carthage
Henderson	M. J. Babcock, Biggsville	Elmer T. Swann, Oquawka
Henry	C. G. Kurtz, Kewanee	P. M. Schmidt, Galva
Iroquois	E. L. Roberts, Watseka	Evelyn Rinallo-Neufeld, Watseka
Jackson	E. R. Carman, 201½ W. Main, Carbondale	R. F. Sondag, 1015½ Chestnut St., Murphysboro
Jasper	G. C. Brown, Ste. Marie	C. O. Absher, Newton
Jefferson Hamilton	Alex E. Fairshter, 1002 Main St., Mt. Vernon	Herman C. Rogers, State Tuberculosis Sanitarium, Mt. Vernon
Jersey	H. E. Wuestenfeld, 201a North State St., Jerseyville	W. Clark Doak, 111 S. Washington St., Jerseyville
Jo Daviess	Ray E. Logan, Galena	L. A. Rachuy, Stockton
Johnson	W. J. Wakefield, Vienna	E. A. Veach, Vienna
Kane	Kenneth G. Bulley, Springbrook Sanitarium, Aurora	Morton Schaffran, 12 Fox Street, Aurora
Kankakee	Charles Whalen, Volkmann Bldg., Kankakee	S. W. Reagan, Aroma Park
Knox	Charles Paisley, Bondi Building, Galesburg	Fred Stansbury, Weinberg Arcade, Galesburg
Lake	Douglas Boyd, 426 Park Avenue, Highland Park	M. J. McAndrew, c/o Abbott Laboratories, North Chicago
LaSalle	William Scanlon, LaSalle	Ralph J. Bailey, Ottawa
Lawrence	Tom Kirkwood, 1906 State Street, Lawrenceville	Charles G. Stoll, 611 State St., Lawrenceville
Lee	Howard Edwards, Galena Avenue, Dixon	T. J. Caldarola, Franklin Grove
Livingston	W. A. Marshall, Locust St., Fairbury	James H. Langstaff, Box H., Fairbury
Logan	Wayne J. Schall, Lincoln	Abraham Wilensky, Lincoln
McDonough	C. L. Weston, Macomb	R. G. Trummel, Macomb
McHenry	J. C. Sculley, Algonquin	Joseph E. McKenna, Fox River Grove
McLean	W. G. Ball, Griesheim Bldg., Bloomington	A. E. Livingston, Griesheim Building, Bloomington
Macon	Maurice D. Murfin, St. Mary's Hospital, Decatur	John W. Little, Jr., St. Mary's Hospital, Decatur
Macoupin	M. W. Buehrig, Carlinville	Joseph J. Grandone, Gillespie
Madison	Charles D. Ehlert, 10 E. Broadway, Alton	E. F. Moore, 110 N. Morrison, Collinsville
Marion	Fritz Katzenstein, Salem	O. J. Burroughs, Centralia
Mason	H. W. Maxfield, Mason City	J. W. McHarry, Havana
Massac	S. P. Ward, Metropolis	G. F. Cummings, Metropolis
Menard	T. V. Plews, Petersburg	H. P. Moulton, Petersburg
Mercer	Harold T. Little, Aledo	John E. Bohan, Alexis

Continued on Page 12

PENTOXYLON®



...and in a matter of weeks

angina loses its terror

- Reduces nitroglycerin need
- Reduces severity of attacks
- Reduces incidence of attacks
- Increases exercise tolerance
- Reduces tachycardia
- Reduces anxiety, allays apprehension
- Lowers blood pressure in hypertensives
- Does not lower blood pressure in normotensives
- Produces objective improvement demonstrable by ECG.

Each tablet of Pentoxylon combines the tranquilizing, stress-relieving, bradycrotic effects of 1 mg. Rauwiloid and the prolonged coronary vasodilating effect of 10 mg. pentaerythritol tetranitrate (PETN). The combination provides a new completeness of treatment previously unavailable to patients with angina. The contained Rauwiloid serves to overcome tachycardia—to permit better coronary filling without increasing cardiac work. This effect, together with the lasting coronary relaxation afforded by PETN, combine to reduce nitroglycerin needs, increase exercise tolerance, reduce anxiety, allay apprehension and produce objective improvement demonstrable by ECG.

Development of full effectiveness of Pentoxylon requires about 2 weeks of therapy, though benefits have been observed after 24 hours.

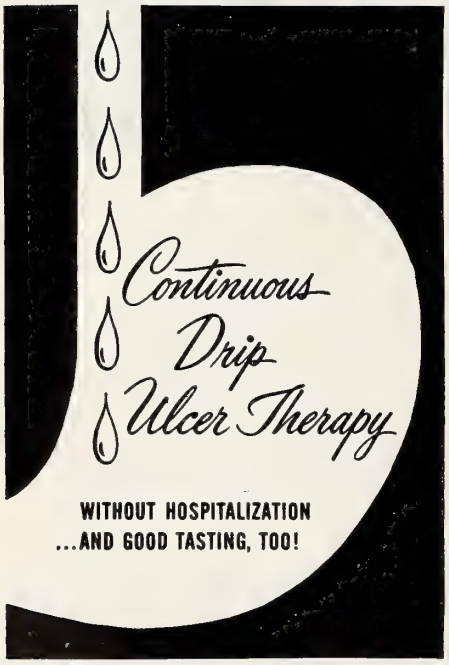
Dosage: Initially, 1 tablet q.i.d. Available in bottles of 100 long-acting tablets.

Descriptive literature on request

Riker **LABORATORIES, INC., LOS ANGELES, CALIF.**

County Medical Society Officers, Continued

COUNTY SOCIETY	PRESIDENT	SECRETARY
Monroe	J. A. Werth, Waterloo	Gerard Dundon, Columbia
Montgomery	C. H. Sihler, Litchfield	Ross W. Griswold, Litchfield
Morgan	Albert F. Fricke, Professional Building, Jacksonville	Frank B. Norbury, Professional Building, Jacksonville
Moultrie	Phillip H. Best, Sullivan	H. E. Kendall, Sullivan
Ogle	Robert F. Dearborn, Byron	Edward A. Glenn, Byron
Peoria	John M. McCuskey, Jefferson Bldg., Peoria	Morton J. Freedman, 1011 Main St., Peoria
Perry	Ben A. Kinsman, DuQuoin	H. I. Stevens, Tamaroa
Piatt	W. N. Sievers, Whiteheath	E. W. Weir, Atwood
Pike	J. H. Ritledge, Pittsfield	M. Shulman, Pittsfield
Pulaski	G. J. Meshew, Mounds	W. R. Wesenberg, Mound City
Randolph	A. C. Scott, Evansville	F. P. Gaunt, Marissa
Richland	Frank C. Weber, Olney	Lawrence J. Knox, Olney
Rock Island	L. J. McCormick, 1630 Fifth Ave., Moline	George A. Cook, 755-15th Ave., East Moline
St. Clair	O. G. Schneidewind, New Athens	Lloyd J. Hill, 417 Missouri Avenue, East St. Louis
Saline	Neva Skelton, 1411 Jackson St., Eldorado	B. E. Montgomery, Harrisburg
Sangamon	David Lewis, Myers Bldg., Springfield	William DeHollander, St. John's Hospital, Springfield
Schuyler	H. O. Munson, Rushville	Henry C. Zingher, Rushville
Shelby	S. D. Taylor, Windsor	H. C. Turney, Shelbyville
Stephenson	Donald J. Doelker, Second National Bank, Freeport	Frank W. Tracy, 321 W. Galena St., Freeport
Tazewell	R. F. Jordan, 410 Elizabeth St., Pekin	R. G. Rhoades, 32 South 4th St., Pekin
Union	William H. Whiting, Dongola	C. D. Nobles, Anna
Vermilion	E. M. Dewhirst, 607 N. Logan Ave., Danville	L. W. Tanner, 7 N. Virginia Ave., Danville
Wabash	C. F. Brian, Belmont	C. L. Johns, 112 West 5th St., Mt. Carmel
Warren	Richard E. Icenogle, Roseville	Henry C. Scholer, Monmouth
Washington	P. B. Rabenneck, Nashville	Roscoe C. Vernor, Nashville
Wayne	Rufus J. Walker, Fairfield	Charles J. Jannings, Fairfield
White	E. W. Dach, Carmi	J. G. Rosenberg, Norris City
Whiteside	M. David Burnstine, 407 First Ave., Sterling	Edgar R. Picken, 101 E. Miller Rd., Sterling
Will Grundy	L. W. Woodruff, 250 N. Ottawa St., Joliet	August Martinucci, 58 N. Chicago Ave., Joliet
Williamson (1954)	Ernest Hennig, Herrin	Edna M. Longwell, 108 W. Cherry St., Herrin
Winnebago	J. S. Moffatt, Brown Bldg., Rockford	W. S. Keenan, Gas-Electric Bldg., Rockford
Woodford	Robert P. Lykkebak, El Paso	Howard T. Barrett, Minonk



HORLICKS CORPORATION
Pharmaceutical Division
RACINE, WISCONSIN

Nulacin

A recent clinical study* of 46 ambulatory nonhospital patients treated with Nulacin† and followed up to 15 months describes the value of ambulatory continuous drip therapy by this method. Total relief of symptoms was afforded to 44 of 46 patients with duodenal ulcer, gastric ulcer and hypertrophic gastritis.

The delicately flavored tablets dissolve slowly in the mouth (not to be chewed or swallowed). They are not noticeable and do not interfere with speech.

Nulacin tablets are supplied in tubes of 25 at all pharmacies. Physicians are invited to send for reprints and clinical sample.

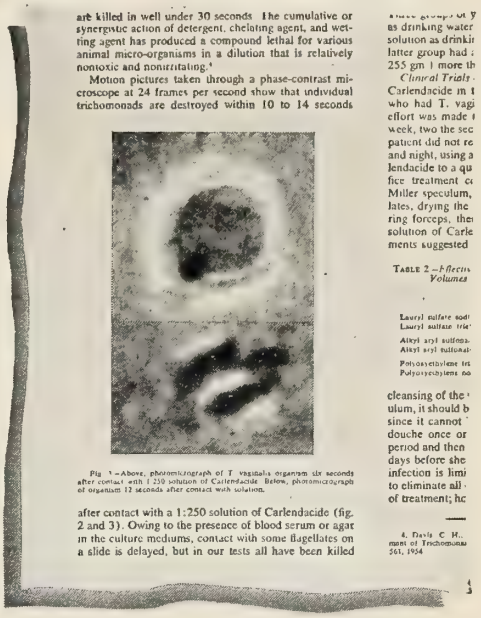
*Steigmann, F., and Goldberg, E.: Ambulatory Continuous Drip Method in the Treatment of Peptic Ulcer, Am. J. Digest. Dis. 22:67 (Mar.) 1955.

†Mg trisilicate 3.5 gr.; Ca carbonate 2.0 gr.; Mg oxide 2.0 gr.; Mg carbonate 0.5 gr.

DESTROYED

"... INDIVIDUAL TRICHOMONADS ARE DESTROYED WITHIN 10 TO 14 SECONDS AFTER CONTACT WITH A 1:250 DILUTION [VAGISEC LIQUID]."

Davis, C. H.: J.A.M.A. *157*:126 (Jan. 8) 1955.



In his new *J.A.M.A.* article, Dr. Carl Henry Davis reviews his experience with the new trichomonacide which he and C. G. Grand, research physiologist, developed under the name of "Carlendacide." Now available as VAGISEC jelly and liquid, it has been shown on clinical trial to clear up even stubborn cases of vaginal trichomoniasis. "Adequate office and home treatment can effect a cure of T. vaginalis infections, if limited to the vagina, within four weeks."[1]

Synergistic action. VAGISEC liquid attacks the trichomonad with three surface-acting chemicals.[2] The *chelating agent* tears out the calcium of the calcium proteinate from the cell membrane of the trichomonad. The *wetting agent* lowers surface tension and removes waxes and lipid materials from the cell membrane. The *detergent* denatures the protein. With the cell membrane destroyed, the cytoplasm imbibes water from its surroundings, swells up and explodes.[3] *Synergism accomplishes this within 15 seconds!*

Thorough peneration. VAGISEC jelly and liquid penetrate the cellular debris and mucoid material that line the vaginal wall and reach hidden trichomonads that lie buried among the rugae. They dissolve mucinous material and explode hidden trichomonads as well as trichomonads on the surface of the vaginal wall.[4]

Trichomonads destroyed in 15 seconds. No other agent or combination of agents kills the trichomonad in this specific fashion, or with the speed of VAGISEC liquid.[2] Dr. Davis studied this action under the phase-contrast microscope and actually *saw* individual trichomonads destroyed within 15 seconds of contact with a 1:250 solution.[1]

Clinical tests. VAGISEC liquid has been clinically tested by over 100 leaders in obstetrics and gynecology. Those who have followed the plan of treatment have had better than 80 per cent of cures among non-pregnant patients with one course of treatment.[1]

The Davis technic.† The Davis technic is a combination of office treatment with VAGISEC liquid and prescribed home treatment with both VAGISEC jelly and liquid.[1] Dr. Davis says that office treatment is an essential part of the technic.

Write for: reprint of Dr. Davis' article,[1] file card giving complete details of Davis technic, and pad of patient instruction sheets for home treatment. Address Julius Schmid, Inc., 423 West 55th Street, New York 19, N. Y.

Bibliography

1. Davis, C. H.: J.A.M.A. *157*:126 (Jan. 8) 1955. 2. Davis, C. H.: Am. J. Obst. & Gynec. *68*:559 (Aug.) 1954. 3. Davis, C. H.: West. J. Surg. *63*:53 (Feb.) 1955. 4. Davis, C. H.: J.A.M.A. *92*:306 (Jan. 26) 1929.

JULIUS SCHMID, INC. *gynecological division*
423 West 55th Street, New York 19, N. Y.

VAGISEC is a trade-mark of Julius Schmid, Inc. †Pat. app. for

Active ingredients: Polyoxyethylene nonyl phenol, Sodium ethylene diamine tetra-acetate, Sodium dioctyl sulfosuccinate. In addition, VAGISEC jelly contains Boric acid, Alcohol 5% by weight.

Mississippi Valley Trudeau Society annual meeting

The date of the 1955 annual meeting of the Mississippi Valley Trudeau Society has been set for October 14, at the Hotel Savery, Des Moines, Iowa.

The day-long meeting on tuberculosis and chest diseases will include papers on pulmonary diseases among the aging population, fungous diseases of the lungs, and respiratory diseases transmitted from animals to man.

The evening session will be devoted to a presentation of world health problems and tuberculosis.

The regional Trudeau Society meets in conjunction with the Mississippi Valley Conference on Tuberculosis, in session October 13 through 15.

Members of the Mississippi Valley Trudeau Society program committee include Harold G. Curtis, M.D., Cleveland, Ohio, chairman; Franklin Top, M.D., Iowa City, Iowa; Paul T. Chapman, Detroit, Michigan; and Michael L. Furcolow, M.D., Kansas City, Kansas.

Pfizer gift box for physicians

A handsome gift package for physicians entering practice has been announced by Pfizer Laboratories, division of Chas. Pfizer & Co., Inc. Designed to acquaint the newly licensed doctor with Pfizer products, the gift box contains stock packages of several Pfizer prescription drugs.

Tyzine, Pfizer's new nasal decongestant, Bonamine, Terramycin and Tetracyn oral suspensions, Terra-Cortril ointment, and a Steroject hypodermic kit complete with throwaway needles and antibiotic cartridges are included in the gift box. They will be presented to the new physician by Pfizer Laboratories representatives.

‹ ›

It is good economics for the well-to-do members of the community to participate in the programs designed to detect, help, and shelter the tuberculous individual who cannot afford to take care of himself. Rene J. Dubos, Ph.D. Am. Rev. Tuberc., July, 1953.

Lederle

GRAVIDOX*

Pyridoxine-Thiamine *Lederle*

For preventing and treating nausea and vomiting of pregnancy

Pyridoxine (B_6) and Thiamine (B_1) have proved more effective in combination than either alone in the prevention and treatment of hyperemesis gravidarum. GRAVIDOX, in tablet and parenteral form, combines these vitamins, providing a nutritional approach to the problem. GRAVIDOX may also be useful for the prevention and relief of nausea and vomiting associated with radiation sickness.

Each GRAVIDOX tablet contains: Thiamine HCl—20 mg., Pyridoxine HCl—20 mg. Each cc. of GRAVIDOX parenteral solution contains: Thiamine HCl—50 mg., Pyridoxine HCl—50 mg.

Average dose: 5 to 12 tablets daily, in divided doses, at times when vomiting is less likely to occur; or 1 cc. parenteral solution 2 or 3 times weekly.

LEDERLE LABORATORIES DIVISION AMERICAN Cyanamid COMPANY Pearl River, New York

*REG. U. S. PAT. OFF.

The
ILLINOIS
Medical Journal

Official Journal of The Illinois State Medical Society

MAY 1955
VOL. 107 NO. 5

Symposium on the

Uses And Abuses Of Chemotherapy And Antibiotic Agents For Infections In Children

L. Martin Hardy, M.D., Howard S. Traisman, M.D., Paul P. Pierce, M.D., and James S. Walker, M.D.

Uncomplicated Upper Respiratory Infections in Children and the Promiscuous Use of Chemotherapeutic and Antibiotic Agents

L. M. Hardy, M.D., Chicago

THE advent of chemotherapeutic and antibiotic agents has brought about many changes in the medical world. Justifiable volumes have been written on the beneficial results in heretofore incurable diseases. Unfortunately, public appeal and professional enthusiasm has carried us beyond the point of scientific use and into the realm of abuse of these valuable and potent medications. There are potential dangers inherent in the use of any therapeutic agent that alters the physiological changes within the body. Because of this fact, the astute physician should and will use all sane diagnostic aids at his command before instituting on faith, hopeful and frequently hazardous medications. It is a sad commentary on our professional integrity and honesty when antibiotics or chemotherapeutic agents are prescribed for an undefined illness in order to placate anxious parents and allay our own insecurity.

This sound promise is particularly applicable in conditions that are potentially and frequently self limited. Numerous serious infections in children initiate their onset with fever, slight pharyngitis, nasal discharge, vomiting and abdominal pain. These symptoms are also typical for the onset of the common cold. A very small percentage of children (15-20%) presenting

Presented before Section on Pediatrics, 113th Annual Meeting, Illinois State Medical Society, Chicago, May 20, 1953.

these initial findings develop complications of the respiratory infection or other disease. Certainly there is good evidence that no chemotherapeutic agents are effective against an uncomplicated upper respiratory infection. Instituting their use at the onset of a fever to prevent complications is open to question and fraught with danger. The question is: What are you treating? The danger is the certainty of inhibiting the manifestations of a clinical picture that would lead to an early diagnosis of a serious correctable disease.

This is especially true when vigorous therapy is instituted in the first few hours after the onset of a fever in a child who has no physical findings other than the hyperpyrexia. Here we are certainly trespassing into a dubious and potentially dangerous situation by medicating an unknown entity. One of the earliest and oldest dictums of our medical education was to withhold opiates when one suspected an acute abdomen. The same conservative approach must be pursued when dealing with acute fevers of undetermined origin. Many of our present chemotherapeutic and antibiotic agents will alter the clinical picture of an infection as certainly as morphine will alter the findings of an acute abdomen. Morphine relieves pain only, but our blind faith in the bacteriostatic and bacteriolytic powers of the antibiotics is not justification for non-specific promiscuous use.

Certainly these views are not new especially to the group of pre-sulfa and antibiotic practitioners. It was our good fortune, out of necessity, to stand by, examine and observe the natural course of disease. It did not take many years of practice to appreciate the fact that nature was kind and that most of the "colds" or fevers in children run a course of 3-5 days with complete recovery. It is the post sulfa and antibiotic medics that must be convinced of the limitations and dangers of our therapeutic armamentarium. Any clinical entity or disease that is diagnosed and clearly known to be benefited by antibiotic or chemotherapeutic agents should and will get prompt and adequate treatment. It is the large group of common indefinite infections to which we are directing our attentions such as the obvious coryzas, the child with fever and slight pharyngitis, and the child with a fever but no physical findings. This large group comprises the major portion of illness in a physician's pediatric practice and one of three things develops. About 75-80% recover with symptomatic treatment, about 6-7% develop measles or roseala and about 15% will develop some complications of the respiratory tract such as otitis, cervical adenitis, bronchitis or pneumonia or some central nervous system infections such as meningitis.

It was with considerable concern and distress that we observed the wide use of sulfas and penicillin in the clinic at Children's Memorial Hospital by the resident staff for fevers and uncomplicated upper respiratory infections. These neophytes had never seen the course of an uncomplicated upper respiratory infection and therefore were giving full credit to their treatment for the 3-5 day recovery. Further and far more serious was the experience of seeing patients that had been treated for a fever which subsided temporarily and medication was discontinued only to find that the recurrent fever did not respond so readily when therapy was again started. Instead the child seemed more ill. At this stage the clinical signs are well clouded and not until a spinal puncture or extensive x-ray and laboratory work reveals the trouble, can proper treatment be given. In the meanwhile much valuable time is lost.

A few specific examples will bring this contention into clearer focus.

J.E. was a well developed, well nourished 9 month old healthy white male infant until March 13, 1953 when he became less active and vomited several times. He was seen by a local doctor and given one penicillin shot and a sulfa preparation. He did not improve and was seen at Children's Memorial Hospital on March 16, 1953. The physical examination at this time was essentially negative and no medication was prescribed. The following day he was seen by another local physician who started large doses of terramycin orally. His condition was worse for a short time with the temperature up to 104 degrees and he began holding his head to one side.

This boy was next seen at Children's Memorial Hospital on March 20 at which time he was not extremely ill but was quite irritable. A full but non-firm fontanelle was the only suggestive neurological finding. A spinal tap at this time revealed 1740 cells with 75% polymorphonuclears. The smear and culture showed Type B Hemophilus influenza in spite of all the previous therapy. The patient was given terramycin 50 mg/kg and streptomycin .25 grm twice daily. The clinical course showed no improvement and increased central nervous system pressure was evidenced by vomiting. Subdural taps revealed 25 cc of yellow

cloudy fluid on the right side. The taps were continued for some time and the medication changed to aureomycin and streptomycin was again started. On April 12, 1953, one month after onset, the child showed some improvement and was finally discharged from the hospital apparently recovered April 24, 1953.

Here again early inadequate treatment in a child with fever so confused the clinical picture that a conclusion was delayed for a week and a prolonged illness followed, with subdural abscess.

K. F. born September 18, 1951 had been a healthy child who had experienced no serious illness except a slight coryza with no fever on December 15, 1952. On January 1, 1953 he became restless, developed fever and vomited. This was thought to be "flu" bordering on pneumonia. Intramuscular penicillin injections were given on 2 or 3 occasions and a sulfa preparation was given by mouth which was vomited and in 1 day aureomycin was substituted for the sulfa. This boy became quite weak and was unable to walk. By January 9, 1953 however he was somewhat improved and tried to walk about. At this point the medication was stopped and the patient did fairly well for 3 days. The fever then recurred, associated with headache. By January 20, 1953 the temperature was over 104 degrees and the child did not recognize his parents. Hospitalization was instituted and the gamut of diagnostic procedures were applied to a confused picture. The blood count was as follows: red blood count 4,420,000; 10.7 grams hemoglobin; and white blood count 15,700. Differential: 73% polymorphonuclears, 25% lymphocytes, 2% cosinophils. The urinalysis was negative. The heterophile antibody, agglutinations, x-ray of the chest and abdomen, intravenous pyelogram, and blood culture were all negative. A transfusion of whole blood was given and intramuscular penicillin 400,000 u daily plus terramycin 125 mg. daily.

Finally a spinal puncture was done revealing 1850 cells, mostly polymorphonuclears. The spinal fluid protein was 69, chlorides 750, and sugar 45. This child had received enough medication to completely distort the clinical picture of meningitis. When the diagnosis was finally made the specific type was still unknown because all cultures produced no growth. This fact alone required longer treatment since the bacteria were unknown. Seven weeks were required for recovery which is considerably longer than most purulent meningitides if adequate specific treatment is started early.

These cases are not recited in detail because of their rarity but rather to give fairly typical examples of the all too frequent pattern that is woven when our ammunition is fired prematurely. This fact is not only true with the so called upper respiratory infections in children but in other fields as well.

Case History *D. G.* born August 15, 1938, had no serious difficulty until January 1951 when he developed abdominal pain, vomiting, and diarrhea. He was hospitalized and given penicillin, streptomycin, and chloromycetin. The acute symptoms subsided but a low grade fever persisted. He was readmitted February 20, 1951 for recurrence of pain and a laparotomy was done with the removal of a ruptured appendix and was discharged March 22, 1951. On June 19, 1951 to July 5, 1951 he was again hospitalized with abdominal pain, vomiting and diarrhea which subsided when treated with antibiotics. In October 1951 he again had a recurrence and had a complete workup with no definite findings.

This patient was first seen by us March 19, 1952 and was hospitalized until March 24, 1952. A complete gastro-intestinal, genito-urinary and laboratory workup revealed no findings. This patient was the only child of fairly anxious parents consequently we were inclined to think these attacks were recurrent gastrointestinal upsets in a spoiled boy who had a low threshold to pain. He was discharged with the instructions to return if and when there was a recurrence.

D.G. was readmitted to Children's Memorial Hospital May 30, 1952 and he had gained ten pounds but had again developed abdominal pain and vomiting. The abdomen was moderately distended but no other findings except a white blood count of 19,000. He had received no medication this time. In view of the past history, the persistence of symptoms, and our lack of diagnostic acumen, it was decided to explore this child. A large abdominal abscess was found and evacuated plus a fecalith and an appendiceal stump. Here again antibiotics had contained but not cured an infection for over 1 year.

Many years ago Brennemann described the common cold and its complications as varying amazingly in symptomatology, localization, and severity from the banal "cold" at one end of the series through the endless maze of possibilities to a fatal septicemia at the other end, without any sharp line of cleavage as to classification or determinable etiology. This is still our plight, because colds or upper respiratory infections still comprise the major portion of pathologic problems confronting the practicing physician.

Nelson states that colds or upper respiratory infections in children do follow a fairly definite pattern at different age levels and it is important to be familiar with these age variations. In the newborn up to 3 or 4 months of age the symptoms of a cold are usually very mild, with slight or no fever, nasal congestion, sneezing, moderate redness of the throat and anoxia. This is followed with a cough which may persist for a week or ten days and gradually subside with rare compli-

cations. Many so called colds in this neonatal period are actually the manifestation of respiratory difficulties resulting from malformations, aspiration, atelectasis, depression of respiratory center, congenital laryngeal stridor, or mediastinal tumors.

In the age group of 5 months to about 3 years the reaction to an upper respiratory infection is frequently quite violent with a high fever for 2 or 3 days, nausea, vomiting and occasionally convulsions. Complications of otitis media, acute laryngitis, sinusitis and pneumonia are more common at this age.

The preschool child and the first and second grader are constantly exposed, consequently colds appear with increased frequency but with a gradual decrease in severity as age and immunity increase.

The older child has less fever reaction but is more apt to complain of sore throat, headaches, aching and anorexia. Complications in this group, if they occur, are usually sinusitis, cervical adenitis, and atypical pneumonia, depending on seasonal incidence.

Knowing the usual course of these infections in children plus the numerous occasions of sad conclusions we were faced with the problem of gathering some concrete facts to prove or disprove our contentions. Also it followed that some simple criteria of screening should be formulated as a guide for a sane and safe plan of therapy for this large group of patients.

With these thoughts in mind a so called upper respiratory infection study was set up and started at Children's Memorial Hospital Out-Patient Department in May 1951. Any child that has or has had a temperature of 101 or higher for 12 hours or more but has no physical findings except a slight pharyngitis is accepted for the study. The routine workup includes a white blood count, hemoglobin, urinalysis and nose and throat culture with antibiotic sensitivity determinations. If the temperature is over 103 degrees a chest x-ray is ordered. The nose and throat culture is repeated on the second visit which is in 2 or 3 days and the child is then followed at intervals, for 2 weeks. At the first visit the child is referred to the pharmacist with a slip stating its weight and age and the druggist rotates the medications through 4 groups adjusting the dosage according to a scale on the basis of weight and age. One group gets a placebo and aspirin, one group gantrisin and aspirin, one group aureomycin and aspirin, and one group oral penicillin and aspirin. In this manner none of the workers have a knowledge of the child's medication until the study is complete. If however a complication develops the type of medication is checked with the pharmacy and adjusted if deemed necessary. The study is not complete but Dr. Howard Traisman will give a report to date on the material collected thus far.

In order to practice what was being preached an additional control study has been carried on in private practice. This group of 80 patients all fit the same criteria but by necessity did not get all the work up or 2nd nose and throat cultures. The improvement and recoveries were checked frequently by phone calls. Complications were seen in the office or at home. With the exception of one or two factors this data coincided fairly closely with the clinic control group. The one and most glaring difference is the wide variation in hemoglobin even though the hemoglobinometers were checked against each other. The only explanation thought of so far for the low hemoglobin in the clinic group is the possibility of poorer diet.

Actually 90% of the hemoglobins were over 12 grams in the private group as compared to about 22% over 12 grams in the clinic group.

The following data is of no great significance by itself but the findings should be kept in mind as they are related to the study that will be presented shortly.

COMPLICATIONS	*PRIVATE CONTROLS*
80 patients	*13 complications*
4 otitis media	3 pneumonia (probable)
1 cervical adenitis	2 tonsillitis
1 paratonsillar abscess	1 pyuria
average onset of complications	1 impetigo and fever
	5.3 days of illness

PRIVATE CONTROL—WHITE BLOOD COUNT, AGE, SEASON, CULTURES

White Blood Count and Complication: 10

counts on 13 complications, 8 counts over 10,000, 2 white blood counts under 10,000.
No complications: 37 counts, 23 under 10,000, 14 over 10,000.

Age: 8 under 4 years, 5 over 4 years
Season: 8 winter, 3 fall, 1 summer, 1 spring
Culture: Hemolytic streptococcus 5 times

CONTROL UPPER RESPIRATORY INFECTION STUDY (PRIVATE)
Complications 16.2%, No complications 78.8%, other disease 5%
White Blood Count over 10,000 in 80% with complications.
Age under 4 years in 69% with complications
69% with complications occurred during the winter season
72.5% recovered in 1 week
23.75% recovered in 2 weeks
3.75% did not recover in 2 weeks
12.8 days for recovery with complications
4.6 days for recovery without complications

It is apparent from the foregoing that during the winter months a child under 4 years of age with a fever and a white blood count over 10,000 is more certain to develop a complication. It is also significant that the complications do not usually manifest themselves until about the fifth day of the illness. Furthermore, as will be shown later, if proper specific antibiotic or chemotherapeutic agents are administered at this time the total period of illness is not prolonged.

A Controlled Study in the Uses of Chemotherapeutic and Antibiotic Agents in Uncomplicated Upper Respiratory Infections in Children

Howard S. Traisman, M.D., Chicago

NUMEROUS articles have been written on the use of chemotherapy and antibiotic therapy in the treatment of upper respiratory infections, or the "common cold". However, to our knowledge, a study such as has been described by Dr. Hardy, has never before been reported.

Coburn[1] reported on the efficacy of sulfadiazene prophylaxis for steptococcal infections in 600,000 navy personnel, with 300,000 men acting as the control series. He noted that the morbidity rate for respiratory disease caused by filterable viruses was unaffected. Rusk and van Ravensway[2] in a study of 670 army personnel found no difference in the course of upper respiratory infections treated with or without sulfadiazene. Janeway[3] found no advantage in the use of sulfonamides in the treatment of viral respiratory infections. Cecil[4] stated that sulfa and penicillin were of no value in the treatment of the "common cold". He believes that "aspirin and scotch" are the best armamentarium the physician possesses for treatment of upper respiratory infections. Of course, Cecil was reporting on his study in a series of adults. Spink and associates[5] conducted a study for the army on the use of sulfa and penicillin in streptococcal infections. They found definite improvement in respiratory infections of streptococcal origin, but infections not due to that organism did not evidence any striking improvement. Mack[6] recommended the use of sulfa as a prophylactic measure, but also stressed the value of good hygiene, diet and rest. Hodges[7] reported a marked improvement in the prevention of beta-hemolytic streptococcal infections with sulfa prophylaxis. "Ordinary respiratory disease" also showed a response to sulfa, possibly because of streptococcus and pneumococcal organisms producing a clinical picture indistinguishable from the "common cold". Of course, he admits that this was strictly an unproven clinical observation. Loosli[8] advocates the use of good health measures, and prevention of spread of droplet infections, as the best prophylaxis of upper respiratory infections. Penicillin, sulfa, and influenza A and B vaccines are of no value in prevention or treatment of the "common

Children's Memorial Hospital, Chicago

cold" according to this author. Loosli believes that every one cannot predict the course of an upper respiratory infection, and that the best treatment is symptomatic. Specific chemotherapeutic and antiobiotic agents should be reserved for complications or bacterial invasion. Broh-Kahn and Erdman[9] reported a marked decline in streptococcal and non-streptococcal respiratory disease with the use of prophylactic sulfapyrazine and sulfadiazene.

Lapin[10] studied one hundred children who were given oral penicillin daily and influenza A and B vaccine twice for 12 months. There was a decrease in the morbidity and number of "colds" in this group. However, a larger series for study was recommended to confirm his results. McLane[11] describes good results in treatment of acute upper respiratory infections in 42 patients with a combination tablet of aspirin, phenacetin, caffeine, phenyltoloxamine dihydrogen citrate (an antihistaminic) and 100,000 units of penicillin.

Finland and associates[12] reported on the use of aureomycin in the treatment of pneumonia. Included in this article was a discussion of "severe acute respiratory infections" treated with aureomycin. They described ten such patients. These individuals who had temperatures of 104 degrees, WBC of 16,000-21,000 were afebrile in 12-24 hours with symptomatic improvement. However, these patients had betahemolytic streptococcus and streptococcus viridans on throat culture.

Hoagland and associates[13] reported on 309 army men who were engaged in a study of the value of aureomycin in the treatment of the common cold. One hundred fifty four men got aureomycin, and there was no difference or improvement in the course of their disease. He noted a great subjective element in the so-called "24 hour curves". An interesting observation was that the worst respiratory infections were in the winter months, and that there appeared to be remarkable improvement in the infection during the spring months.

In summary, it might be said that there have been no well controlled studies reported on the use of antibiotics and sulfonamides in the treatment of the common cold. Finland[14] and Karelitz[15] both stress the fact that neither the sulfonamides nor the antibiotics (penicillin, aureomycin, chloromycetin and terramycin) are effective in the treatment of the common cold or common virus diseases. Evidence in support of this are the numerous children in hospital wards who are receiving one or more of the aforementioned drugs, and develop an upper respiratory infection or influenza. These drugs should be reserved for the treatment of bacterial complications of the common cold.

I would like to mention the role of the antihistaminics in relation to this problem. A summary of the literature[16] proved the antihistaminics to be of no value in the treatment or prophylaxis of the upper respiratory infection. The danger of death from overdosage of these drugs must always be remembered.

Smith[17] presents a classical discussion of the common respiratory infection, and stresses the importance of good, general supportive, or symptomatic care. An example of the needless anxiety of the parents, and the needless expense to which they are often time submitted is described by Smith, and I quote: "I see many patients in consultation whose parents have been subjected to great and needless expense, as well as to undue anxiety. For example, a child with an acute pharyngitis, or "grippe" with a red throat is treated with sulfonamides for two or three days. If the fever does not yield promptly, as it often does not, especially when the general care of the child has been neglected, the patient is rushed to the hospital. Penicillin intramuscularly is usually started at once and given every few hours, the pain disturbing the child's rest. Orders are given for complete blood counts and cultures, urinalysis, x-ray of chest, lumbar puncture, throat cultures, etc., etc. The parents eagerly wait the results of the many tests. Before they are all reported the patient is usually convalescent, for the four-day fever has run its normal course, in spite of the treatment! When the hospital bill is rendered, the shock to the parents does not endear the physician to them. The small child is often left in a nervous and unsettled state from being taken out of his familiar home into the hospital, where strangers do painful things to him, mostly unnecessary, and where he is often neglected in essential matters."

REPORT OF STUDY

1.—*Method of study as described in the previous paper*

2.—*159 patients were studied; being divided into four groups.*

group 1—was composed of 55 patients, who acted as controls, receiving a placebo.

group 3—was composed of 37 patients, who received gantrisin.

group 4—was composed of 35 patients, who received aureomycin.

group 5—was composed of 32 cases, who received penicillin.

3.—*Average days of illness prior to beginning of treatment*

group 1—1.7 days, group 3—1.9 days, group 4—2.4 days, group 5—2.2 days for an average of 2 days

4.—*Occurence of complications* (pneumonia, otitis media, etc.); group 1—11 patients or 20%, 9 patients or 16.3% required additional treatment, 2 patients or 3.6% recovered on treatment being administered to that group *alone;* group 3—9 patients or 24.3%, 6 patients or 16.2% required additional treatment, 3 patients or 8.1% recovered on the group treatment alone; group 4—7 patients or 20%, 4 patients or 11.4% required additional treatment, 3 patients or 8.5% recovered on group treatment alone; group 5—6patients or 18.7%, 3 patients or 9.3% required additional treatment, 3 patients or 9.3% recovered on group treatment alone.

The total average occurrence of complications regardless of treatment was 21.2%, 16.3% of complications required additional treatment in the control group. 12.3% of complications required additional treatment in groups 3, 4, and 5. 4% of complications were corrected by immediate antibiotic treatment.

5.—*Age of patient in relation to complications* 74% of the patients were under 4 years of age.

6.—*White Blood Cell Count and complications* 68% of all the WBC done were under 10,000/cu.mm., 66% of the WBC in patients with complications were under 10,000/cu.mm.

7.—*Hemoglobin determination* 75% of the patients in the study had a hemoglobin under 12 grams.

8.—*Time of complications* 75.2% of complications occurred after 5 days in all groups, 27.2% of complications occurred after 5 days in control group, 62.5% of complications occurred after 5 days in treated group. (Possibly this is one reason for the longer recovery period for the treated groups. The question of whether the treatment postponed the onset of complications must be raised)

9.—*Recovery Rate* Control group—56% recovered in 1 week, 34% had recovered in 2 weeks, 10% took over 2 weeks to recover. Treated groups—39% recovered in 1 week, 48% recovered in 2 weeks 13% took over 2 weeks to recover.

10.—*Drug reactions* group 1, 3, and 5—none, group 4—2 instances of diarrhea (1 with vomiting) 1 instance of a rash on the trunk. A total of 3 reactions in 104 cases or 2.9%.

11.—*Bacteriology* Pathogens were considered hemolytic and non-hemolytic staphylococcus, hemolytic and non-hemolytic streptococcus, pneumococcus, and H. influenza. In the treated groups—48 pathogens and 20 non-pathogens were found on the first culture. Forty pathogens and 24 non-pathogens were found on the second culture. In the control group—38 pathogens and 11 non-pathogens were found on the first culture. 31 pathogens and 13 non-pathogens were found on the second culture. Much has been written concerning the overgrowth of staphylococci with the use of antibiotics. Seventy instances of staphylococcus and 8 instances of hemolytic staphylococcus were found on the first culture. 30 instances of staphylococcus and 8 instances of hemolytic staphylococcus were found on the second culture. However, only 17 instances of staphylococcus and 1 instance of hemolytic staphylococcus persisted on both cultures. 47 cultures of staphylococcus on the first culture were in the treated groups. This decreased to 16 instances in the second culture. Only 7 instances persisted on both cultures in the treated groups. We found no preponderance of staphylococcus overgrowth in our series.

SUMMARY

A review of the literature concerning studies of the efficacy of the use of chemotherapy and antibiotics in the treatment of the "common cold" has been presented. These agents are of no value in the treatment of upper respiratory infections.

In our series of 159 patients, 55 being control

subjects, complications occurred in 21.2% of all patients studied. 16.3% of the control group required additional treatment of the complications. In the treated groups 12.3% required additional treatment for the complications and 74% of all complications occurred in patients under 4 years of age. Complications occurred after 5 days of study in 27.2% of the control group and 62.5% of complications occurred after 5 days of treatment in the treated groups. (Possibly the therapy postponed the onset of complications).

Recovery was more rapid in the control group —56% recovering in 1 week and 34% had recovered in 2 weeks. Ten per cent required more than 2 weeks to recover. The treated groups has 39% recovering in 1 week; 48% in two weeks; and 13% required more than 2 weeks. We are unable to scientifically explain this fact.

Sixty per cent of total white blood cell counts in patients with complications were under 10,000 cells/cu.mm.

In the treated groups, 48 pathogens and 20 non--pathogens were found on the first culture, and 40 pathogens and 24 non-pathogens were found on the second culture. The control had 38 pathogens and 11 non-pathogens on the first culture, and 31 pathogens and 13 non-pathogens on the second culture. There was no apparent staphylococcus overgrowth in any of the cultures, especially those receiving specific therapy.

BIBLIOGRAPHY

1. Coburn, A. F., Mass sulfadiazene prophylaxis of respiratory diseases in the U. S. Navy. Bull. New York Acad. of Med. 2:282, 1945.
2. Rush, H. A., van Ravensway, A. C.—Sulfadiazene in respiratory tract infections; its value in the treatment during winter of 1942-43 at Jefferson Barracks, Mo. JAMA 122:495, 1943.
3. Janeway, C. A.—The use of sulfonamides in the treatment of respiratory infections in children. New Eng. J. of Med. 229:201, 1943.
4. Cecil, R. L.—Chemotherapy in acute upper respiratory infections. Bull. New York Acad. Med. 2:263, 1945.
5. Spink, W. W., Rantz, L. A., Boisvert, P. J. Coggershall, H.—sulfadiazene and penicillin for hemolytic streptococcus infections of the upper respiratory tract. An evaluation in tonsillitis, nasopharyngitis, and scarlet fever. Arch. Int. Med. 77:260, 1946.
6. Mack, J. K.—The prevention of respiratory infections in children including sulfonamide prophylaxis. Ill. Med. J. 98:224, 1950.
7. Hodges, R. G.—The use of sulfadiazene as a prophylactic against respiratory disease—New Eng. J. Med. 231:817, 1944.
8. Loosli, C. G.—The problem of control of the respiratory tract infections. J. Lancet 69:245, 1949.
9. Broh-Kahn, R. H. and Erdman, G.—Sulfapyrazine: Its use in the prophylaxis of respiratory disease. Amer. J. Med. Sc. 212:170, 1946.
10. Lapin, J. H.—Prophylaxis of upper respiratory infections in children by oral penicillin and influenza virus vaccine inoculation Arch. Pediat. 64:121, 1947.
11. McLane, R. A.—Clinical evaluation of combined drug therapy in acute upper respiratory infections. J. of Med. Soc. of New Jersey 49:509, 1952.
12. Finland, M., Wells, E. B., Collins, H. S., Gocke, T. M.—Aureomycin in the treatment of influenza and certain other acute respiratory infections with and without pneumonia. Am. J. Med. 8:21, 1950.
13. Hoagland, R. J., Deitz, E. H., Myers, P. W., Cosand, H. L.—Aureomycin in the treatment of the common cold. New Eng. J. Med. 243:773, 1950.
14. Finland, M.—Antibiotic treatment of acute respiratory infections and influenza. New Eng. J. of Med. 247:557, 1952.
15. Karelitz, S.—Choice of an antibiotic—J. Pediat 42:492, 1953.
16. Editorial—The antihistaminic drugs and the common cold J. Pediat. 38:534, 1951.
17. Smith, C. H.—The treatment of common respiratory infections J. Pediat. 37:423, 1948.

Symposium Continues ☞

The Rational Use of Antibiotics and Sulfonamides in the Treatment of Respiratory Tract Infections

PAUL P. PIERCE, M.D., Alton

THIS portion of the symposium will be concerned only with the use of the antibiotics and sulfonamides in the treatment of those infections of the lower portion of the respiratory tract. Dr. Walker's paper will give consideration to those complications of the upper respiratory tract such as tonsillitis, otitis media, cervical adenitis and others. Most of the diseases which I shall discuss are complications of or associated with simple upper respiratory infections, although some seem to be primary in their origin.

The decision which the physician must make when he must treat a child who is ill with a respiratory infection is not always an easy one if he gives it serious and conscientious consideration. Assuming that he can make a correct diagnosis, the indications for therapy with potent antibiotics and chemotherapeutic agents are not always clear. Of course, the acutely ill child with pneumonia or acute laryngotracheobronchitis is a certain candidate for one or more of these life-saving drugs, but I believe that all of us recognize that we are guilty of using them too frequently in borderline cases where symptomatic therapy might be sufficient. It is my opinion that the decision should often rest on the correct answer to several pertinent questions:

1) Is the child ill enough at this time to warrant the use of an antibiotic or a sulfonamide?

2) If the drugs are not used, will he likely become worse and develop complications or fail to recover within a reasonable time so that such medication will eventually have to be used anyway?

3) Will there likely be any detrimental reactions from the drugs used, either as immediate toxic effects or at a future time such as drug sensitization or the promotion of the tendencies to develop more resistant strains of infective agents?

4) Does the illness warrant the financial expenditure for the drugs which may be prescribed, as well as the inconvenience and discomfort to the patient and to his parents which the proper use of the therapeutic agent may entail. The latter is in consideration of the parenterally administered drugs and the "around the clock" use of oral preparations which may be disturbing to the entire household.

Most of the illnesses which I shall consider here are in the category to which an affirmative answer to those questions could rightfully be given. With the wide variety of antiinfective agents which are at our disposal for use, however, the decision as to whether one of these potent drugs is needed should often engage more of our time and thought than the actual selection of which one is to be used.

Before discussing the treatment of various diseases of the lower respiratory tract, I should like to discuss some points in general about agents of choice, modes of administration of the drugs and a review of a few facts about the different agents which are commonly employed for respiratory diseases.

AGENTS OF CHOICE

Some of the factors which are to be considered are:

1) *Susceptibility of the causative agent of the infection.* This depends largely upon isolation, identification and employment of in vitro sensitivity tests on the cultured organism. While this is often impossible or impractical for treating a large percent of our patients seen in the office or at home, it should be carried out as much as possible on seriously ill hospitalized patients.

2) *Tolerance of the patient to the drug.* Sensitivities to sulfonamides and antibiotics are less frequently seen in pediatric patients than in adult practice, but toxic effects on renal, hepatic, nerve and the blood-forming tissues are known to occur all too often. Minor reactions to the drugs such as fever, skin rashes, and severe gastro-intestinal upsets should not be disregarded

or considered too lightly. The parents should be informed of the particular drugs to which their child has shown an adverse reaction so that more severe damage may be avoided in the future by the injudicious use of the same preparation.

3) *Economic Factors.* Where several suitable agents are available for use, we should have our patient's interest in mind to use the less expensive materials if they are likely to give comparable benefits. It behooves us to learn the retail prices of many of the newly introduced antibiotics so that the economic factors may be considered.

4) *Ease of administration.* Parents should always be asked whether their child can (and will) take medication in the form of tablets, capsules, or liquids and what flavor is preferred when the drug may be prescribed or compounded to fit the taste. Tablets and capsules are usually more economical and are often easier to administer, especially at night, if the child is old enough to swallow them.

5) *Multiple agents.* The increasing tendency to use multiple agents for treatment of infections is probably often unwise except in case of serious illness, especially where the causative germ cannot be readily identified. It has been shown that there are no combinations of drugs which are consistently synergistic in their actions against infective agents. It is also recognized that certain combinations may exert antagonistic effects and therefore hinder the patient's progress. This is probably most often true when a bacteriostatic drug such as a broad spectrum antibiotic is used in combination with one whose action is chiefly bactericidal such as penicillin. The increased cost of several drugs instead of one is to be given consideration, as is the increased possibility of inducing more toxic effects, more sensitization, and production of more resistant bacterial strains.

MODE OF ADMINISTRATION

1) Day and night use must often be impressed upon the parents who otherwise will often not awaken the child for medication.

2) The length of the course of therapy is very important. While no fixed time for administering a drug can be given for any one particular infection, we need to be careful to warn the parents that stopping the medicine too soon will often result in incomplete cure with recurrence of symptoms later. Too many mothers conclude that they may safely stop the treatment as soon as the symptoms such as fever or cough have subsided, even though the medication may have been given for only a day or two.

3) "Tapering-off" of the medication may be permissible and profitable with certain infections if the full therapeutic dose is given until after the patient is much improved. Then reduced doses or lengthened interval for administration may be recommended for an additional period of days in order to clear any slight residual of infection. However, development of resistant strains of organisms may be more likely if the dose of the drug is too small or if it is used for too long a period of time.

CONSIDERATION OF THE PARENTS

1) Make the medication as easy to administer as possible. This means prescribing a suitable form of the medication — liquids for the younger child — and tablets or capsules for the older child only if it has been ascertained that they are able to swallow them. It is very helpful to have asked the child himself what color or flavor he prefers if there can easily be a choice (as in the case of some of the compounded sulfonamide suspensions). Even the parents appreciate our thoughtfulness in that matter.

2) As has been mentioned, we should avoid the use of the very expensive medications which may produce a financial hardship upon some parents, when a less expensive preparation might serve equally well.

3) It is at times advisable to inform the parents of the name of the medication which is being prescribed. This may prove helpful to them later to have the knowledge of which drug reacted favorably or unfavorably on their child. On the other hand, it is a disadvantage for some parents to be aware of what medicine their child is receiving. This is especially true in the case of some who are unduly apprehensive and who have had some acquaintance with adverse effects of some of the antibiotics or sulfonamides.

4) Concise directions need to be given as to how medication is to be administered at home. Thus, it is often wise to state specifically on the directions that it is to be taken "every four hours, day and night", rather than just "every

four hours". Also it is wise to direct that all of the medication should be used. Otherwise, it may be given for only a short time and discontinued as soon as the child seems to be better. Such cases frequently flare up a few days later and have to have treatment started over again.

5) The problem of the parents refilling prescriptions for sulfa and antibiotics repeatedly and using them without the knowledge of the physician, has been made somewhat less difficult recently by the new laws regarding this matter. If we give our consent, the pharmacists will still continue to refill them upon the patient's request. While it requires many more phone calls into our offices, I believe it to be in the best interests of the patient and of medicine in general to have strict provisions against refilling. A postal card sent to each of the pharmacists in the area in which a physician practices, informing him of unwillingness to have any prescription refilled without specific permission, will do much to avoid this problem.

AVAILABLE ANTIBIOTIC AND CHEMOTHERAPEUTIC AGENTS

1) *Sulfonamides.* Despite the production of penicillin and the various broad spectrum antibiotics, the sulfonamides continue to occupy a very important place in the treatment of various respiratory infections. Their relatively good coverage of bacterial infections, plus their economy and ease of administration are definite points in their favor. The use of the combinations of sulfas as well as the production of the newer more soluble forms of gantrisin and elkosin have considerably reduced the incidence of renal damage and the need for a large fluid intake.

A distinct advantage of using sulfonamides is the ease and economy of the "tailor-made" prescription according to the weight of the child. The usual dose of one to one and one-half grains per pound of body weight per 24 hours is usually employed. For respiratory infections where cough is present, the sulfa drugs can be put into suspension with various suitable cough syrups or expectorants along with a palatable fruit flavored syrup base. It is inadvisable to give sulfonamides concurrently with certain cough syrups which contain antihistamines and ephedrine however. Children have been found to get over-stimulation of the nervous system with resulting hallucinations which may be very distressing.

2) *Penicillin.* Penicillin is, of course, very widely used in its various forms for respiratory infections by the parenteral and oral routes. While it is still a leader among the drugs used for combating the various gram negative and gram positive coccal infections, it is disturbing to view the ever increasing number of reports concerning the penicillin resistant strains, especially among the pathogenic staphylococci. Also the increasing number of sensitivity reactions in adult patients makes us wonder how prevalent such occurrences may be when the present pediatric group has grown a bit older, having received the drug frequently since infancy. The new stable salt of penicillin (dibenzylethylenediamine dipenicillin-g) which may be given orally or parenterally has been found to provide longer periods of effective blood levels, thus the doses may be given farther apart.

Neo-Penil which produces a higher level of penicillin in the lung tissue has been recommended for certain chronic pulmonary infections. This has recently been reported to have been responsible for some severe reactions, and thus must be used with proper caution. A warning against its use in small infants has been issued by the company which produces it.

3) *Aureomycin, terramycin* and *chloromycetin* have gained very wide usage in recent years due to their broad range of effectiveness. In general, these drugs have comparable ranges of effectiveness against most bacterial infections.

Since a rather recently recommended reduction in the dosage for aureomycin has been adopted, the distressing side effects of the drug have been reduced and it has regained some of the popularity which it seemed to have lost in many areas. Terramycin is perhaps slightly better tolerated by the patients and can be made into somewhat more palatable and more stable liquid preparations for oral use. Considerable financial saving to the patient can be afforded by having the pharmacist remove the terramycin from the capsules and suspend it in a suitable tasting syrup instead of using the flavored preparations provided for sale by the drug manufacturer. When used for bronchitis or pneumonia, certain cough medicines may be mixed with the syrup and a mixture produced is "tailor-made" for the

particular patient according to his size and his symptoms. The chief advantage other than economy is that only one dose of medicine is needed instead of one of antibiotic and one for the cough. Aureomycin, terramycin and chloromycetin can be administered intravenously to the acutely ill patient and recently it has been reported that terramycin can be safely given as a subcutaneous infusion.

Since reports of severe aplastic anemia associated with chloromycetin therapy have appeared, this drug has been prescribed less frequently except for certain specific indications for which there are no adequate substitutes. The palmitate of chloromycetin is very palatable and is well tolerated by most pediatric patients.

4) *Streptomycin* and *dihydrostreptomycin* remain very useful for specific indications, but are used less than formerly because of the toxic effects on the auditory nerve and because of the tendency to produce resistant strains of bacteria. Contrary to early reports about dihydrostreptomycin, it has not proven to be less damaging to the eighth cranial nerve than streptomycin, so the latter is again being used more widely. Penicillin and streptomycin seem to work synergistically against certain bacterial infections and combinations of streptomycin and sulfadiazine are known to be quite effective in treating infections due to H. influenzae.

5) *Erythromycin* and *magnamycin* have been introduced recently as new wide sprectum antibiotics which seem to exert their greatest effect against the gram positive cocci. They have not yet become as popular as the other abovementioned antibiotics. Perhaps when they are available in a suitable liquid form, they may be used more extensively and to greater advantage in pediatrics.

APPLICATION OF THE ANTIBIOTICS AND SULFONAMIDES TO TREATMENT OF COMMON INFECTIONS OF THE LOWER PORTION OF THE RESPIRATORY TRACT

1) *Simple spasmodic croup* (acute catarrhal laryngitis). This distressing condition which is almost always associated with a mild nasopharyngeal infection may often be treated adequately without the use of drugs other than expectorants if plently of steam or cool vapor can be provided in order to liquefy the viscid mucus which obstructs the laryngeal opening. If the croupiness is too severe or if the associated nasopharyngitis is marked, it is desirable to prescribe one of the sulfonamides or an antibiotic.

2) *Acute Epiglottis* represents one of the more serious types of infections which we may be called upon to treat. In this condition the severe degree of laryngeal obstruction may develop so rapidly that we are confronted with a true medical emergency. The epiglottis and supraglottic structures are often made so edematous by the infection that early tracheotomy may have to be done in spite of chemotherapy. The influenza bacillus is often cultured from the nasopharynx or may be obtained from blood cultures taken prior to specific therapy. Occasionally the presence of influenza bacillus meningitis may be discovered also in these critically ill children. Some evidence that viral agents may play a part in the etiology of this type of infection has been presented. The specific therapy of this infection can be carried out with a number of different agents if an adequate air-way is provided. Thus, a trial should be given the patient in an atmosphere of high humidity, with oxygen as needed, being careful to resort to tracheotomy early enough if the child is becoming exhausted. Treatment with sulfadiazine and streptomycin given parenterally in the early stages is usually very effective. The broad spectrum antibiotics may be given parenterally at first and later by the oral route and are also quite beneficial.

3) *Acute laryngotracheobronchitis* is also a very serious disease which produces severe toxemia along with a marked degree of respiratory obstruction. The latter is the result of subglottic edema plus the formation of thick plugs of mucus secretion along the tracheobronchial tree. Hemolytic streptococci and staphylococci are said to be the most common bacterial agents which are responsible for this infection. An atmosphere high in humidity, along with the use of oxygen and the newly introduced wetting agents which are so helpful in liquefying mucus, are tending to reduce somewhat the need for tracheotomy in these cases. The sulfonamides and antibiotics have likewise played a very important role in reducing the mortality in the disease. Penicillin, streptomycin, and sodium sulfadiazine may all be employed by the par-

enteral route in the extremely ill child before the results of throat and blood cultures are available. The antibiotics such as chloromycetin, aureomycin or terramycin have also been reported to exert a very beneficial effect. These may be given parenterally at first and then orally a little later after the patient has improved.

4) *Acute bronchiolitis* occurs chiefly in infants of three to eighteen months of age. It is characterized by rapid, labored, respirations with an audible wheeze and signs of emphysema. There may or may not be a significant temperature elevation. A very noticeable feature is the manner in which the accessory muscles of respiration are brought into use. Abdominal breathing seems to be more prominent than the thoracic type. Air exchange is poor in spite of this, due to the bronchospasm and emphysema. On examination of the chest, the abnormal findings are diffusely distributed throughout both lungs.

Treatment with the wide spectrum antibiotics plus expectorant mixtures containing ephedrine have proved very effective in my experience. Aureomycin oral drops in doses of five milligrams per pound of body weight given in a small amount of milk seems to be both effective and well tolerated. High humidity and oxygen are also helpful. A combination of penicillin and streptomycin may be used with good results where parenteral therapy is necessary.

5) *Acute catarrhal bronchitis* is usually associated with upper respiratory infection and seems to be recurrent with some children almost every time they get a common cold. The severity is quite variable depending upon the age of the child and upon the infecting agent. Usually, treatment with a sulfonamide or oral penicillin plus a suitable cough syrup and the use of steam or cool vapor is effective within a few days.

Another type of bronchitis which has been presumed to be due to a viral agent has been rather commonly observed. Here, the child is often almost entirely free of any upper respiratory symptoms and often is afebrile. He may feel fine except for the cough which is chiefly nocturnal or perhaps more related to sleeping. The mothers report very little coughing except when the child lies down to sleep, either for a daytime nap or at night. Then he develops a deep, distressing and at times paroxysmal type of cough with much choking on mucus — at times to the point of vomiting. Examination reveals minimal abnormal findings in the lung field, which may consist of somewhat harsh breath sounds usually with very few rales. A leukopenia is usually present and the differential leukocyte count reveals a relative lymphocytosis — frequently 70% to 80%. X-rays of the chest reveal nothing more than midly accentuated lung markings. Symptomatic treatment is usually of little benefit, and in most cases I have found little beneficial effect from sulfonamides and not much more from penicillin. Antibiotic therapy has, however, been found to be quite effective in most cases if aureomycin, terramycin or chloromycetin are employed. Terramycin suspended in a palatable cough syrup and diluted further with a fruit flavored syrup gives both symptomatic and specific treatment in every spoonful. The dosage used is relatively small — usually five to ten milligrams per pound of body weight given in doses every four to six hours. Thus a 2½ year old child weighing thirty pounds might have the following prescription:

Rx Terramycin ..... 750 mgm.
Cough syrup ..... 35.0 cc
Syr. Sweet Cherry q.s. ..... 90.0 cc
Sig: One teaspoonful every four hours for 48 hours, then one teaspoon every six hours until all is used.

The above prescription will, I believe, cost the parent about one fourth to one third less than a liquid terramycin preparation of comparable strength, not to consider the additional cost of the cough preparation which might be prescribed.

This type of bronchitis seems to be recurrent with some children over a period of several months, so that the physician may come to know what the effective treatment will be from the mother's description of the symptoms.

Another recurrent type of bronchitis is the so-called asthmatic bronchitis which some believe should be termed intrinsic asthma. The children who suffer from this type often have an allergic background and exhibit other manifestations of hypersensitivity. Upon contracting mild respiratory infections, they develop severe coughing and wheezing with some temperature elevation and toxicity. Treatment with most any of the anti-infective drugs is often helpful in terminating the attacks which do not tend to

cease readily with antiasthmatic treatment only.

6) *Pneumonia* no longer presents the severe therapeutic problems in most cases as it did in the days prior to the sulfonamides and antibiotics. To parents, however, the diagnosis still stands as a spectre which stirs much apprenhension. Indeed, many cases of lobar pneumonia in children give some of the most dramatic therapeutic results obtainable in most any field of medicine. The sulfonamides and penicillin are usually about equally effective in early eradication of the acute symptoms after only a few doses.

Not so easy to cure are the cases of bronchopneumonia which complicate severe upper respiratory infections, exanthemata, and certain chronic systemic diseases. Here, the physician often must use multiple agents concurrently or a method of trial of different agents successively until the infection has been finally eliminated.

Primary atypical pneumonia of viral etiology is likewise more often a therapeutic problem. In these cases, the data which have been published concerning the actual effectiveness of the various drugs are not too convincing. However, there seems to be sufficient evidence in favor of aureomycin and terramycin to warrant a trial with one of these. Since viral studies are not generally available, the exact causative agent in most of such cases has to be presumed to be viral on the basis of physical findings, x-ray studies, leukocyte counts, etc. In actual practice, many infections thought to be of viral origin may not be so. The use of a broad spectrum antibiotic is thus more likely to bring the desired results in absence of a known etiologic agent.

7) *Empyema* and *pleural* effusions are now seen less frequently than before the use of the antibiotics and sulfonamides. An occasional case is still seen where adequate treatment of a pneumonia has been delayed or not given. The treatment of the pulmonary infection plus simple aspiration of the pleural space is often sufficient to cure the patient. Instillation of aqueous solution of penicillin into the pleural space is also helpful, but in some instances, open or closed surgical drainage must still be resorted to.

601 E. 3rd Street

REFERENCES:

1. Dowling, Harry F. and Lepper, Mark H. Practical Problems in the Use of Antibiotics Med. Clin. of N.A. **36** p. 247-262. 1952.
2. Schwachman, Harry and Kennell, John H. Newer Antibiotics in Pediatrics. Med. Clin. of N.A. **35** p. 1507-1522 1951.
3. Hunt, Andrew D. Jr. Antibiotics in Pediatric Practice Md. Clin. of N.A. **36** p. 1607-1618 1952.
4. Baty, James M. and Kriedberg, Marshall B. Acute Laryngotracheobronchitis. Med. Clin. of N.A. **36** p. 1279-1288 1952.
5. Finland, Maxwell, Antibiotic Treatment of Viral Diseases. Med. Clin. of N.A. **36** p. 1239-1252 1952.
6. Graves, Fay B. and Ball, Walter O. Evaluation of the Treatment of Primary Atypical Pneumonia with Aureomycin, Chloromycetin, and Terramycin. J. Ped. **39** p. 155-167 1951.
7. Jawetz, E. and Gunnison, J. B. Studies on Antibiotic Synergism and Antagonism. A Scheme of Combined Antibiotic Action. Antibiotics and Chemotherapy **5** p. 243-247 1952.

Symposium Continues ☞

The Failure of Antibiotics and Chemotherapy in Otolaryngology

JAMES S. WALKER, M.D., Urbana

THE otolaryngologist probably appreciates the true value of antibiotics and chemotherapeutic agents better than a member of any other specialty. Within ten years, the practice of otolaryngology has undergone a complete change. Despite the large variety of miracle drugs available, we have not designated any one as the ideal to combat all infections. Perhaps it is in the offing. Rather than live in anticipation, it is my impression that we should review critically the manner in which we are using, or perhaps misusing, the wonderful medications at hand today. Sufficient time has elapsed so that the limitation as well as the merits of these aids can be determined.

To control and eradicate infection, we depend upon medicinal agents or surgical interference. Prior to the advent of antibiotics and chemotherapy, great emphasis was placed upon surgical procedures; now, the emphasis is almost entirely upon medical therapy.

SLIDE I

FOR CONTROL OF OTOLARYNGOLOGIC INFECTIONS

(1) ACCURATE DIAGNOSIS
   a) History and physical exam
(2) MEDICAL THERAPY
   a) Antibiotic or chemotherapy
   b) Supportive measures
(3) SURGICAL THERAPY
   a) Urgent — incision and drainage
   b) Planned — removal of path. tissues

History and physical examination are still requisites for the planning of effective treatment. This is especially true in pediatrics. It is well known that the presenting complaint many times is unrelated to the pathology uncovered by thorough examination. As an example, diarrhea can be initiated by otitis media and abdominal pain may occur with upper respiratory infections. An error in diagnosis usually results from lack of observation rather than a lack of knowledge.

Successful medical therapy requires the selection of an agent and its proper administration. The final choice depends upon the experience of the doctor and tolerance of the patient. The maze of literature, both scientific and promotional, is sometimes helpful but also confusing as an aid in this procedure. It is far better to acquire a working knowledge of a few of the wonder drugs than a reading knowledge of many. In addition, it is advisable to introduce the newer medications into one's practice slowly. The unfortunate mental and legal entanglements of the sulfa elixir episode should not be permitted to recur. Just recently a new product, Neo-Penil,® which combines penicillin with iodine has been under investigation. Fourteen anaphylactoid reactions resulting in three deaths have followed the use of this preparation. Thus the advantages to be gained by the use of a new drug should be appraised carefully in advance.

Surgical therapy may be considered under two headings, namely (1) the urgent surgery which is provided by incision and drainage and (2) the planned or prophylactic surgery which is necessary to prevent recurrent infections and their disabling sequelae.

SLIDE II

FAILURE OF ANTIBIOTICS OR CHEMOTHERAPY

(1) FAULTY DIAGNOSIS
(2) IMPROPER ADMINISTRATION
(3) LACK OF SURGICAL JUDGMENT

The failure of a specific antibiotic or chemotherapeutic agent is not necessarily the fault of the drug. Other equally important factors which contribute to failure are (1) a faulty diagnosis, (2) the improper administration of the medication, and (3) Lack of surgical judgment. The failure to combine medical and surgical therapy happens too frequently in otolaryngological infections. It is amazing to compare the physi-

From the Department of Otolaryngology, Carle Memorial Hospital and Carle Hospital Clinic, Urbana, Illinois.

cian's attitude towards pain in the right lower quadrant with pain in the ear. In the former, sedatives are strictly withheld and in questionable cases, an appendectomy is considered the conservative procedure of choice. Yet, illogical as it may seem, the patient with the bulging tympanic membrane from pus under pressure often may receive antibiotics but no surgical relief. The lack of needed drainage may nullify the medical therapy.

Adenotonsillitis: One of the infections most frequently encountered in children is adenotonsillitis. This term is more nearly accurate than tonsillitis because the adenoid is usually involved in the same process. The inflamed lymphoid tissue may enlarge tremendously and in the nasopharynx a mechanical obstruction can occur. The interference to physiological nasal drainage favors the development of otitis media and sinusitis. The acute infections usually subside promptly with medical care. In many instances recurrences are common and call for a change in the agent used. Finally a state may be reached in which hyperplasia or chronic infection exists. Surgical judgment is necessary in these cases. For example, in 1947 and 1948, the press contained glowing accounts of the marvelous cures effected by the antibiotic and chemotherapeutic drugs. In the face of this publicity our staff continued to perform adenotonsillectomy in carefully selected cases. A follow-up study was conducted 3 to 4 years postoperatively and the parents of 100 children subjected to surgery were asked to express their opinions.[2] Results were based upon objective findings as listed in the following table:

Symptoms	*Pre-Op*	*Post-Op*	*Improved* %
Otalgia	45	11	75
Aural Discharge	22	8	63
Impaired Hearing	28	3	89
Mouth Breathing	47	6	87
Adenopathy	45	1	98
Cough	26	4	85

The above study indicates the continued need for tonsil and adenoid surgery. The day of indiscriminate removal of these structures should be a thing of the past but the temporary control of frequent recurrent infections afforded by antibiotics and chemotherpy should not and can not supplant the lasting advantages gained by surgery.

Pain in the ear is another common complaint in childhood. This may signify an infection of the pinna, ear canal, tympanic membrane, or middle ear.

Otitis Externa: Otitis externa may occur either as a diffuse or localized inflammatory reaction. The basic therapy is local treatment but the antibiotics and chemotherpy may be used in the presence of spreading cellulitis or regional adenopathy. Occasionally incision and drainage will be necessary.

Myringitis Bullosa: Myringitis bullosa is a common finding in upper respiratory infections when a virus or "flu" etiology is suspected. The formation of a bleb filled with serous or blood tinged fluid is similar to the herpes simplex of the nose and mouth. Pain may be intense during blister formation but of short duration. The bulla ruptures readily. The curative powers of the wonder drugs are questionable, but may prevent the onset of secondary purulent invaders.

Otitis Media: Otitis media is no longer dreaded as a complication of the common cold, measles, scarlet fever and similar childhood diseases. In fact, the otolaryngologist seldom is consulted any longer in the treatment of otitis media. This trend is not surprising and not objectionable provided the attending physician has learned the limitations of conservative medical therapy and is prepared to furnish or recommend surgical drainage without hesitation. For ease of classification otitis media may be considered as either a non-purulent or purulent process.

Otitis Media, Non-Purulent: This general term includes catarrhal otitis, serous otitis, and otitis media with effusion. An acute or chronic state may be present. Pain may be present in the acute stage. Within the middle ear space, there is an accumulation of sterile fluid which may be serous or mucoid in character. Many adults have experienced this condition without recognition. The symptoms are those of fullness in the ear accompanied by the sensation of hearing ones own voice as if shouting into a rain barrel and an urge to clear the ear by popping it. The more common causes include an upper respiratory infection, allergy, and sudden air pressure changes experienced either in flying or forceful clearing of the nose. Any basic nasopharyngeal pathology such as adenoids, neoplasms or recurrent infec-

tions may produce a chronic situation. The adult usually recognizes the abnormality but the child will seldom complain. An alert parent will note inattentiveness in the child and suspect hearing difficulty; a school audiogram may reveal hearing loss; or an observant doctor will make the diagnosis on routine examination. Fluid within the middle ear is usually characteristic but failure to recognize it is common. The use of a 512 tuning fork will demonstrate that bone conduction is better than air conduction. Impaired hearing secondary to the accumulation of fluid within the middle ear is reversible and it is highly important to diagnose this condition promptly. This problem is of growing importance because many otologists on the basis of good evidence believe that the use of antibiotics and chemotherapy has increased the incidence of otitis media with effusion.

Otitis Media, Purulent: In the purulent type a severe earache may call attention to the ear. The parent and many times even the physician may consider the onset of pain as the first indication of middle ear infection. Actually, pain in purulent otitis media represents the final stage of a progressive involvement. The tympanic membrane usually is thickened, full of bulging, red or gray, and the constitutional reaction may include fever, emesis, irritability, and toxicity. This is the patient who is in desperate need of drainage for pus under pressure. Surgical drainage alone will effect a cure in 95 to 97 per cent of the cases as proven in the days before antibiotics or chemotherpy. However, it is well recognized that surgery plus the use of these agents will bring about a complete cure within a much shorter period of time and the incidence of complications will be practically nil. Unfortunately experience has shown that the wonder drugs act to relieve pain. The substitution of drugs with their masking effects may satisfy the patient and parent but the physician who knowingly neglects to provide necessary free drainage is adopting a precarious course of therapy.

Other complications of ear, nose and throat infections include cervical adenitis, sinusitis, mastoiditis, retropharyngeal abscess, peritonsillitis, orbital cellulitis and meningitis. Many of these conditions may require surgical as well as medical therapy.

The following case history is not unusual

D.B., a 5 year old white male, was first seen 8-29-52, with the complaint of (1) mouth breathing, (2) mucoid or purulent nasal discharge, (3) earaches, (4) impaired hearing and (5) recurrent sore throats. The symptoms had been present for two years. Antihistamines along with every known antibiotic and chemotherapeutic agent had been employed without improvement. Three separate series of skin tests had been done and although inconclusive the parents were convinced that he was an allergic child. On examination there was slight bilateral cervical adenopathy; both tympanic membranes were intact but severely retracted and the middle ear mucous membrane was cyanotic; bone conduction was greater than air conduction and there was marked loss to conversational and whispered voice; the nasopharynx was packed with adenoid tissue which prevented nasal breathing; and the tonsils were enlarged grade III. A diagnosis of hypertrophic obstructive chronically infected tonsils and adenoids; otitis media with effusion, was made. An adenotonsillectomy was performed on 12-2-52. The adenoids weighed 4½ grams, the right tonsil 5 grams and the left tonsil 5½ grams. A postoperative check ten days later revealed a marked improvement in hearing, breathing, eating and general behaviour. He was seen again one month later and despite a fresh upper respiratory infection his improvement was maintained. No medical therapy was needed.

Constructive criticism: Previous examinations had failed to differentiate between: (1) ANTERIOR NASAL OBSTRUCTION secondary to abnormal turbinates, foreign body, polypi, deviated septum, imperforate choanae and allergy or (2) NASOPHARYNGEAL OBSTRUCTION secondary to hypertrophic adenoids, neoplasm, or adhesions.

An erroneous diagnosis of allergy led to improper and unsuccessful therapy.

The second illustrative case history:

J.M., a 6 year old white male, was first seen 2-9-51, because of (1) Recurrent ear aches, (2) fever, (3) upper respiratory infections. In the past several weeks he had had all the above complaints. A variety of treatments had been used which included six days each of penicillin, chloromycetin, triple sulfonamides, a 500 cc. blood transfusion, and 3 x-ray treatments to the nasopharynx. At no time in all the years of complaint had his ears drained either spontaneously or by virtue of surgical interference. An adenotonsillectomy had been done in May 1950, with no apparent benefit.

On examination a thickened left tympanic membrane with slight bulging of Shrapnell's area was seen. An x-ray of the mastoid showed clouding and an early loss of bony substance. A myringotomy released purulent fluid under pressure. Intramuscular penicillin and oral gantrisin were given. Recovery was complete within 18

days. One year later an acute left otitis media cleared promptly following a paracentesis plus antibiotic therapy. The diagnosis was: Acute left mastoiditis secondary to acute otitis media of the purulent type.

Constructive criticism: LACK OF SURGICAL JUDGMENT caused failure.

In summary, the physician who

(1) makes an *accurate diagnosis* on the basis of history and thorough physical examination,

(2) selects an appropriate agent,

(3) employs it properly,

(4) and exercises sound surgical judgment, will successfully combat infection.

REFERENCES

Severe Anaphylactoid and Fatal Reactions to Penetharnate Hydriodide (Neo-Penil®). J.A.M.A.:151:1105 March 28, 53 (No. 13)

Walker, Jas. S.: Parental Evaluation of Tonsil and Adenoid Removal, Arch-Otolaryng. 67:664-668, June 1953.

Walker, Jas. S.: Parential Evaluation of Tonsil and Adenoid Removal, Arch-Otolaryng. Tto be published.

Potassium–Sodium Relationship in Protein Metabolism

Paul R. Cannon, M.D., Chicago

THE field of potassium metabolism has developed rapidly in the past few years. In looking at the background material for this seminar, however, I was amazed how slowly we have applied knowledge which has been available for several years. As is usually the case in the progress of medicine, technical factors have accelerated the application of basic facts to clinical science. In the field of potassium metabolism, the flame photometer and the electrocardiogram have been particularly useful.

Only in recent years has it become possible to study intracellular electrolytes. Such studies have been a natural consequence of the failure to correct intra-cellular water and electrolyte deficits by the use of extra-cellular fluids. The problem which I would like to discuss today, therefore, is the relationship of extra-cellular sodium to intra-cellular potassium.

Let us first consider some of the ways in which potassium is lost. This may occur as a result of sudden shifts of electrolytes, as for example, in periodic paralysis, or in the course of glycogen formation in the liver following vigorous therapy with glucose and insulin. Loss may be caused, also, by diminished intake, as postoperatively or by an increased out-put due to: (a) prolonged acidosis or alkalosis, or in any catabolic state, (b) in relation to the use of drugs such as DOCA, ACTH, and cortisone, (c) diarrhea or emesis, and (d) inability of renal tissue to conserve potassium during periods of low intake.

Although it is frequently said that potassium is the most important intracellular ion, one may challenge this statement at least with respect to phosphorus ion. As a matter of fact, however, it is probably unwise to state that any essential

Chairman, Department of Pathology, University of Chicago

SEMINAR
of the Department of Medicine of the University of Illinois

Edited by:

Dr. Max Samter
Associate Professor of Medicine
Dr. Alexander Remenchik
Clinical Instructor in Medicine

ion is more important than another in the bodily economy.

Carcass analysis of human subjects has shown that there are approximately 115 grams of potassium in the body, distributed about as follows: 3 grams in the extracellular fluid, 8 grams in the blood, 0.3 grams in the plasma, and the remainder in muscle. The concentration in the muscle, therefore, is approximately 18 times that of the blood.

Newburg has shown that the daily potassium requirement in normal man is approximately one gram. It has been shown that in starvation there is approximately a 10:1 loss of nitrogen to potassium, and this loss remains constant. It has been assumed that this loss is the result, largely, of muscle tissue catabolism, but this cannot be entirely true since some potassium, at least, is not bound.

The importance of potassium for life can not be underemphasized. Potassium is needed for muscle contraction, for nerve action, and for glycogen formation. Some sort of reciprocal relationship appears to exist between sodium and potassium. The problem why potassium enters the cells is of basic interest. Its presence within cells is possibly due to the fact that potassium was present in the sea when life began to evolve. In recent year, enzymologists have shown that potassium is necessary for the action of certain enzyme systems, particularly those involving the formation of high energy bonds. It is of particular interest that sodium inhibits these enzymes. It is possible that creatine exists in muscle as dipotassium salt.

The role of potassium in growth has been clearly shown. Certain amino acid hydrolysates will not engender growth unless potassium is added to them. Rats which have been depleted of protein can be made to undergo protein repletion by feeding diets whose nitrogen comes from a mixture of sixteen (16) synthetic amino acids. If potassium is omitted from the dietary mixture, the rats will fail to undergo protein repletion.

Elimination of phosphate ion will also interrupt repletion even more profoundly than elimination of potassium, and deficit of both ions is more serious than a deficit of either alone.

Continued potassium deficiency in the course of protein repletion of protein-depleted rats causes congestive heart failure. At autopsy there is massive necrosis of the myocardium, non-inflammatory edema, and mild pulmonary congestion. The myocardial lesions are completely reversible if potassium is added to the diet, and after two weeks, necropsies reveal a normal myocardium. Clinical observations support our experimental findings. Patients who died of hypopotassemia may show marked disintegration of muscular tissue. A patient with leukemia who received extensive cortisone treatment, developd myocardial lesions strikingly similar to those seen in experimental animals with potassium deficiency. Similarly, DOCA administered to experimental animals produces (1) myocardial lesions (2) respiratory paralysis, and often a diabetes insipidus.

The lesions which I have described as characteristic of potassium deficiency in the rat do not develop if sodium is also omitted from the diet. In other words, a shortage of sodium modifies both the effects of protein and potassium depletion. If animals which have been fed diets deficient in potassium and sodium are injected subcutaneously with sodium chloride, they die quickly, often within thirty minutes after injection. The post-mortem examination shows a coagulation necrosis of myocardial fibers, suggesting that in the course of potassium deficiency sodium ion may become toxic.

Question: (name of inquirer not recorded)

Do rats ever develop lesions of the type you have described spontaneously?

Dr. Cannon:

I have never observed the spontaneous occurrence of such lesions.

« « « » » »

Emergency Tracheal and Bronchial Conditions

Stanley H. Bear, Major USAF (MC)

IN the practice of medicine, there are only two absolute emergency conditions, blood loss through hemorrhage, and respiratory obstruction. While there are various means of controlling blood loss, only two methods are available for the correction of respiratory obstruction. These are the removal of the existing cause, or bypassing the site of the obstruction for the purpose of establishing and maintaining a patent airway.

In conditions leading to respiratory obstruction, one should be familiar with the underlying physiopathology in order to be aware of its impending or existing signs. Obstruction of the upper respiratory tract occurs in a variety of diseases and conditions ranging from an acute infection, through foreign bodies and tumors, to any of those states in which the self-cleansing mechanisms of the respiratory passages are depressed, paralyzed, or interfered with. Such obstructions constitute a threat to the patient's life, since they may suddenly change from an apparently compensated state to a fulminating and fatal asphyxia. It is important to realize that true anoxia is experienced only in cases of sudden respiratory obstruction resulting from a foreign body, or acute edema or trauma where complete obstruction takes place. In most cases, a state of hypoventilation exists, resulting in blood changes, namely, hypercapnia, anoxemia, and acidemia. These asphyxial blood changes provide a powerful respiratory stimulus which aids in the maintenance of breathing in the face of obstruction resistance. If the obstruction and resulting hyproventilation progress, a crucial point arises where the asphyxial blood changes cease to behave as respiratory stimuli, and the breathing effort weakens, or is actually inhibited eventually. The result is a vicious cycle of a fulminating and self-accelerating asphyxia which may terminate abruptly and fatally.[1] Thus the physician is confronted with the treacherous problem of gauging the present status of the patient's condition and predicting its future course as a basis for deciding between conservative management or immediate correction of the existing condition.

It is impossible to list all of the causes producing respiratory obstruction, but some of the more common ones are:[2]

Congenital disorders of the newborn such as a web, tracheo malacia, and tracheal and bronchial-esophageal fistulae.

Foreign bodies, either metallic or vegetable.

Acute infections, such as laryngo-tracheo-bronchitis, or diphtheria.

Allergy, drug sensitivities producing an angioneurotic edema, spasms, or mucous plugs.

Neurogenic disturbances such as in involvement of the central nervous system, poliomyelitis, tetanus, and botulism.

Trauma from fractures of the trachea and larynx, deep lacerations of the neck and chest injuries, poisonous gases, caustics, and irradiation.

Obstruction due to the postural factor, as exhibited in the debilitated patient, head injury, coma or shock cases.

Granulomatous conditions, such as scleroma, tuberculosis, syphillis and leprosy.

Tumors, both benign and malignant.

Postoperative conditions, such as bilateral abductor paralysis following thyroid surgery, and neurosurgical and chest surgical cases.

Senior Resident, Illinois Eye and Ear Infirmary, Department of Otolaryngology, University of Illinois College of Medicine, Chicago, Illinois.

Presented before the Metropolitan Chapter of the American College of Surgeons, John B. Murphy Hall, April 14, 1954, Chicago, Illinois.

The opinions expressed are those of the author and do not necessarily represent the opinion of any department of the Department of Defense.

Post-anesthetic conditions.

Obstetrical cases, namely toxemia of pregnancy or eclampsia.

Respiratory obstructions can be divided into two general categories, those of the mechanical obstructive type, such as produced by infections, diphtheria or tracheal bronchitis, and those of the secretory obstruction type as in poliomyelitis, head and chest injuries.

The essential factor in the treatment of both types is the establishment of a clean airway for Oxygen exchange and Carbon Dioxide release by the pulmonary tissues. Unfortunately this point is often forgotten and treatment is postponed until there is marked cyanosis, asphyxiation, or an increasingly rapid pulse, with heart failure resulting.

The important point to consider in the treatment of the mechanically produced type of obstruction is the immediate problem of relief of impending asphyxia. If the obstruction persists, increased negative intra-thoracic pressure may produce secondary pulmonary changes such as edema, congestion, exudate or hemorrhage, atelectasis, and emphysema. These conditions may in turn cause infections leading to pneumonitis, lung abscesses or bronchiectasis. Therefore, early intervention should be carried out before irreversible changes take place.

Specific management of the mechanically obstructive type may be carried out as follows:[2]

Absolute physical and mental rest to lower the patient's Oxygen need.

The administration of Oxygen by catheter, hood, or tent, with adequate humidification.

Adequate fluid intake by mouth and parenterally to relieve dehydration and help liquefy the secretions.

In some cases, an Aerosol inhalant containing Tryptar or Alivar for the liquification of crusts and mucous plugs.

No Atropine or opiates should be given as Atropine tends to thicken the secretions, while opiates depress the respiratory center and diminish the patient's conscious effort to help breathe. Before opiates are given to any patient for restlessness or irritability, it should be made certain that this is not an early sign of lack of Oxygen due to a respiratory obstruction.

If secretion plugs or crusts cause blocking, postural irrigation is necessary, and can be carried out with 5 to 10 cc. of 5% warm solution of sodium bicarbonate, or normal saline, followed by immediate aspiration.

If obstructive signs are present, the bronchoscopic removal of crusts and plugs may be necessary.

Expectorants are of questionable value in these conditions.

In the secretory type of obstruction,[3] many of the points listed in the management of the obstructive type still prevail; however, one faces the additional problem of the inability to remove secretions in the tracheal-bronchial tree. These secretions result from either a pharyngeal muscle paralysis, or an absent cough reflex, or a limited or absent accessory respiratory chest muscle action. Therefore, it is emphasized that the prime requisite is the establishment and maintenance of a clean airway.

In the early treatment of the secretory type, postural drainage and continuous suction either by a Venturi type pump or central vacuum type are very important steps. When one first notes beginning pharyngeal paralysis as by a muffled voice or inability to swallow secretions, the patient should be placed with the foot of the bed elevated and the neck extended (or with the face down if it is a child) so fluids may accumulate in the nasopharynx, hypopharynx or cheek.[2] From these points, it can be easily removed by suction. Since the patient is frequently unable to swallow food without danger of spillage into the trachea, or aspiration of vomitus material, adequate maintenance of nutrition and fluid balance becomes an important factor. Approximately 3000 ccs. of fluid should be given parenterally each day. Proper electrolyte balance must be preserved. High dosages of vitamin C and B-complex should be given parenterally, and adequate caloric intake must be upheld.

When secretions cannot be removed by postural drainage, aspiration and repeated bronchoscopic removal, an early tracheotomy is definitely indicated.

During the past few years, tracheotomy has come into much wider acceptance. Its purpose is twofold: first, to establish an airway, and second, to allow an easy access for removal of bronchial secretions by aspiration, and prevention of pulmonary complications. It further

gives a direct route for the maintenance of high humidity and the administration of Oxygen. It bypasses pharyngeal secretions and permits deglutition to function during respiration. And lastly, it permits the use of a respirator in the presence of accumulated pharyngeal secretions and laryngeal spasm.

The definite indications for the performance of a tracheotomy are any signs of impending asphyxia due to obstruction, as exhibited by restlessness of the patient, cyanosis, retractions of either the suprasternal, supraclavicular or Xyphoid areas, absence of breath sounds, or an anxious facies.[4] Signs of exhaustion such as tachycardia, tachypnea, hyperpyrexia and degrees of stupor, coma or convulsions are also indications. When any of the latter occur, it is an absolute indication for a tracheotomy, although most cases reaching this stage may have irreversible cerebral damage and it is too late for a tracheotomy to be helpful.

There are two types of tracheotomy, the tranquil, and the emergency. In most cases, a tranquil or orderly tracheotomy can be performed. In so doing, any impending obstruction is relieved by passing a bronchoscope, a Mosher lifesaver tube or endotracheal tube into the trachea. This furnishes an airway and the tracheotomy can be performed in an orderly fashion.

The following steps can then be taken:[4]

1. A sandbag is placed beneath the shoulders of the patient and the head and neck are fully extended, keeping the chin and nose in midline with the suprasternal notch. This position is maintained throughout the operation.

2. The skin is prepped and 1% procaine anesthesia with epinephrine is infiltrated from the hyoid bone to the suprasternal notch, including the deeper tissues of the midline.

3. An initial midline incision from the prominence of the thyroid cartilage to the suprasternal notch is made, through the skin and superficial fascia.

4. The incision is then deepened in the midline to the thyroid, cricoid and tracheal cartilages, being careful not to skeletonize the larynx and trachea. Any bleeding is controlled by hemostats.

5. Next, the thyroid isthmus will be encountered. In atrophic states, it can be moved upward or downward so as not to interfere with entrance into the trachea, but in most cases it will be necessary to grasp with two large Kelly hemostats, and bisect it by a vertical midline cut between the hemostats. Each stump is properly ligated.

6. For tracheal fixation. a tenaculum or hook is passed through the interannular membrane at the lower border of the second ring in the midline. With the hook under the second ring (not sticking in), the trachea is lifted and fixed.

7. The trachea is incised, caudad from the hook through the third, fourth, and fifth tracheal rings. Caution is necessary to avoid puncture of the posterior lying tracheo-esophageal party wall.

8. Though there may be a hiss of air as the trachea is incised, the edges of the incision usually approximate so tightly that little air passes. A Trousseau dilator or a hemostat is inserted and the tracheal incision spread.

9. In inserting the tracheal cannula, the piloted distal end must be seen to pass through the tracheal incision. The pilot is usually blown out by a tussive blast of air. If not, it should be quickly removed.

10. The wound is loosely packed with sterile gauze and the incision is not completely closed, to allow easy access for re-entering if necessary.

11. A drain is not necessary, and a 4x4 gauze can be used around the cannula. At this point, the cannula is maintained in place by tying the gauze tape around the patient's neck.

In those cases where asphyxia is imminent, an emergency tracheotomy is necessary. To perform this, the patient is placed in a tracheotomy position, and no anesthesia is used. The larynx is held in the fingers of the left hand, while the forefinger palpates the midline of the cricoid cartilage and thyroid notch. A quick incision is made exactly in the midline from the cricoid almost to the jugulem. The forefinger is inserted into the wound and the tracheal rings are palpated. The tip of the knife is then pushed into the tracheal lumen alongside the fingertip, keeping to the midline. The handle of the knife is inserted to open the tracheal wound, being careful not to punch the underlying esophagus, and the tracheotomy tube is inserted. If no tube is at hand, a hemostat will serve to keep the trachea open until a

tube can be secured. The patient is turned on his side and the head lowered to prevent blood from entering the trachea. If he has ceased to breathe, artificial respiration and Oxygen may be given immediately. Once breathing is established, means can be taken for hemostatis.[5]

One cannot complete a discussion of a tracheotomy without a word on constant, careful post-operative care of the airway and the tube.[6] It should be made certain that the tube fits properly and does not cause pressure on the trachea. It should be cleaned daily and secretions and crusts aspirated as necessary from below the level of the tube. The proper amount of moisture should be maintained.[7] In case the patient is in a respirator following a tracheotomy, care should be exercised to see that the tube opening is outside of the respirator.

SUMMARY

There are two methods available for the correction of respiratory obstruction, either by removal of the existing cause, or bypassing the site of obstruction for the purpose of establishing and maintaining an airway.

There are numerous causes of respiratory obstruction and in initiating treatment, one must have an understanding of the physiopathology involved and the difference between a true anoxia of sudden respiratory obstruction, and the chronic hypoventilation state of the secretory obstruction. The essential factor in the treatment of both types is the establishment of a patent airway. Specific management of the mechanically obstructive type is outlined in detail, as well as the secretory type.

An early tracheotomy should be performed when there are any indications of impending asphyxia due to obstruction. There are two types of tracheotomy, tranquil and emergency. In most cases, the tranquil can be performed. The operative steps of both the tranquil and emergency tracheotomy are outlined in detail. Following tracheotomy, constant post-operative care of the airway and tube are of paramount importance.

CONCLUSION

In present-day medicine, there should be little need for a true emergency tracheotomy if one is aware of the impending signs of respiratory obstruction, even of a minor degree. When it is felt necessary to establish an airway by means of a tracheotomy, the physician should have no hesitancy in doing so, as it is a relatively simple procedure and all doctors should be aware of its merits.

904 W. Adams St.

BIBLIOGRAPHY

1. Gray, John S.: The Physiology of Respiratory Obstruction, Annals of Otology, Rhinology and Laryngology. **59**:72-77, (March) 1950.
2. Galloway, Thomas C.: Treatment of Respiratory Emergencies Including Bulbar Poliomyelitis, Springfield, Charles C. Thomas, 1953, p. 7; ibid. p. 14; ibid. p. 44.
3. Von Leden, Hans: Tracheotomy in Chest Injuries, The Illinois Medical Journal, **104**:181-186, (Sept.) 1953.
4. Jackson, Chevalier, and Jackson, Chevalier L.: Broncho-esophagology, Philadelphia, W. B. Saunders Company, 1950, p. 133; ibid. p. 141.
5. Morrison, W. W.: Diseases of the Ear, Nose and Throat, New York, Appleton-Century-Crofts, Inc., 1948, p. 592.
6. Holinger, Paul H.: Personal communication to the author.
7. Reynolds, J. T., Holinger, P. H. Andrews, A. H. Jr., Young, J. P. Jr., and Marlowe, W. H.: Role of Tracheotomy in the Postoperative Care of Patients Subjected to Esophagectomy, Archives of Surgery, **61**:211-228, (August) 1950.

Recognition and Diagnosis of DIABETES MELLITUS

Lucille A. Sprenger, M.D., Peoria

RECOGNITION and diagnosis of any disease is based upon the physician's historical and medical background, his observation of the patient, his knowledge of the disease and ability to correlate findings. Having recognized a disease, the diagnosis must be established. It is at this point that we are grateful to our predecessors for tests which are available to us.

Prior to 1920, diagnosis of diabetes mellitus was based upon the presence of symptoms of the disease. Later, symptoms and glycosuria made the diagnosis. There were undoubtedly a few cases of glycosuria who, today, would be reclassified as renal glycosuria. On the other hand, many borderline or sub-clinical cases of diabetes must have escaped detection.

Before continuing with the clinical picture and procedures for diagnosis, let us go back and review briefly the work of those who first recognized diabetes, first called it by its name.

In Egyptian medical writings already old in the time of Moses there is mention of polyuria.[1] However, it was relatively late in history before diabetes was recognized and its symptoms clearly described.

Aulus Cornelius Celsus, contemporary with Christ, gave the first description of diabetes. Aretaeus of Cappodocia (30-90 AD), living under the Emperor Nero, was the second to describe it and the first known to have called it by the name diabetes, "to run through" or "a siphon".[2] In one passage he stated, "The patients urinate unceasingly; . . . . . The patients are tortured by an unquenchable thirst."

It was an Oxford University professor, Thomas Willis, living in the 17th century who made the simple observation that the urine of the diabetic is "wonderfully sweet, as if imbued with honey or sugar". Dobson, one hundred years later, completed the discovery of Willis when he grasped the fact that the sweet substance in diabetic urine is sugar. The adjective "mellitus" was added to the name of the disease by William Cullen (1709-1790).

We come now to Claude Bernard whose scientific career began in 1847. In was Bernard who performed the first reasonably accurate quantitative determination of blood sugar. His determinations were later proven to be high, but, it was now realized that glycosuria in diabetes resulted from hyperglycemia. In 1928, Folin evolved the procedure which we use today for blood sugar determination utilizing a small specimen of blood.

The date of onset of diabetes is usually indefinite, its approach insidious. In adults particularly is this true. In children a more rapid onset is the rule. In 1,009 adults and 489 children studied by Dr. Priscilla White, 86% of the adults had an indefinite onset, an onset which could not be located within a two month period.[3] A gradual onset, appearing within an interval of two months to one week, was noted in 44% of the children and only 9.4% of adults.

In the first visit with our patient we obtain the family history. Over 50% of the diabetic children have a family history of diabetes. Persons most likely to develop this metabolic disturbance are from diabetic families. How frequently a diabetic member of a family is the first to recognize the disease in a sibling, a mother, or father! Recently a patient of mine returned home to visit his mother. He was shocked to find her looking badly. Weight loss was obvious and complaints of tiredness and excessive thirst meant only one thing to him. Urine tests and post-prandial blood sugars confirmed the diagnosis.

Loss of strength, polyuria, polydipsia, and polyphagia are the most common symptoms of diabetes. Table I is concerned with two series of patients studied by Dr. Joslin in 1920 and 1926.[4] Loss of strength in the 1926 series is the chief symptom, being present in three-fourths

Presented before the Section on Medicine, 114th Annual Meeting, Illinois State Medical Society, Chicago, May 20, 1954.

Table I
Presenting Symptoms of 200 Consecutive Cases of True Diabetes
First Seen in 1920 and 1926

	1920 100 cases No. Cases	1926 100 cases No. Cases	Total (200 cases) No. Cases	Per Cent
Loss of weight	23	19	42	21.0
Loss of strength	46	73	119	59.5
Polyuria	74	69	143	71.5
Polydipsia	65	62	127	63.5
Polyphagia	25	55	80	40.0
Pruritus, skin, and gangrene	12	42	54	27.0
Pains in extremities	17	17	34	17.0
No symptoms	9	12	21	10.5

*Joslin, E. P. et al. Treatment of Diabetes Mellitus, Lea & Febiger Philadelphia, 4th Edition, 1928.

of the cases. Polyuria was next in frequency, occurring in 69 cases. Polydipsia was noted in 62%, and over one-half of the cases gave the history of polyphagia. Pruritus vulvae is frequent and loss of weight common. Blurred vision is not an uncommon complaint.[5] It has been interesting to me that patients frequently deny all symptoms and yet a few weeks after insulin is begun they return to the office stating how well they feel. No longer are they so sleepy and tired. It has been estimated that 12% of diabetics have no symptoms. Bear in mind, however, that freedom from symptoms does not mean immunity to complications.

While many diabetics have no signs of their disease, careful examination usually detects certain abnormal findings. The appearance of fatigue, the dryness of the skin are common findings. Rapid weight loss, especially in the young patient, suggests the possibility of diabetes. Most clinical signs are due to complications of the disease, e.g. pain and gangrene of the legs, poor vision due to cataracts or retinopathy, skin lesions, and diabetic neuropathy.

Obesity has been sited as the most important precipitating factor in diabetes. Obesity, or the history of its occurrence, is noted in 70 to 80% of diabetic patients.[6] We, as physicians, are acutely aware of the problem. But do you realize that the increased death rate in the obese from diabetes is two and one-half times greater than among a similar group who are under-weight? As the degree of over-weight increases, the margin between that of the obese and that of normal people widens rapidly. The death rate from diabetes of those who are 25% or more over-weight is more than eight times that of the normal weight person and thirteen times greater than of those who are under-weight.[7]

Figure 1 was prepared by Dr. Dublin and Mr. Marks for the Metropolitan Life Insurance Company. Note the marked increase in mortality from diabetes among the obese patients. In our search for diabetes, the obese patient, and especially the obese patient with a history of diabetes in the family, is under suspicion.

Symptoms, as related by the patient, and your observations may suggest diabetes, but they

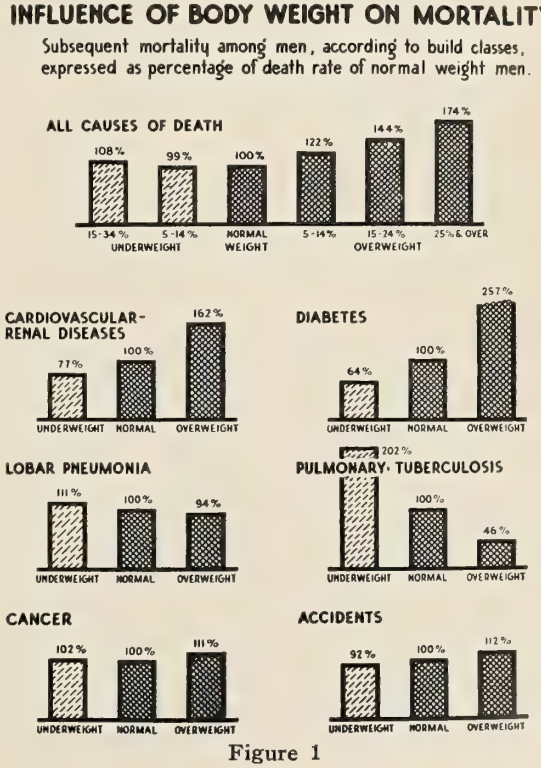


Figure 1

Table II
DIAGNOSIS OF DIABETES MELLITUS

I	RANDOM BLOOD SUGAR AND URINE TESTS	
	1. Fasting blood sugar	130 mgm % or more and glycosuria
	2. Post-prandial blood sugar	170 mgm % or more and glycosuria
II	GLUCOSE TOLERANCE TEST	
	Seldom needed—used infrequently	
	Absolutely contra-indicated if fasting or post-prandial blood sugar levels and urine tests are diagnostic	

do no more than that. An awareness of the significance of glycosuria makes the diagnosis of diabetes mellitus relatively easy. The oft repeated dictum, "glycosuria means diabetes until proven otherwise", must be remembered. A blood sugar should be taken to verify our presumptive diagnosis when glycosuria is found. It is unnecessary to send the patient away to return in the morning for a fasting blood sugar. The post-prandial blood sugar is more likely to give us the evidence for which we are searching. In other words, a random blood sugar and urine sugar may give us our diagnosis. Taking advantage of the fact that, "every meal is a food tolerance test"[8], it is recommended that a blood sugar and urine sugar be taken one to one and a half hours after a meal. If results are conclusive, the glucose tolerance test should not be performed. In table II you will note diagnostic levels: a fasting blood sugar of 130 mgm percent or more, with sugar in the urine; a post-prandial blood sugar of 170 mgm percent or more, with glycosuria. If arterial blood is used, the diagnostic level, post-prandially, is 200 mgm percent.

If the random blood sugar determination is not diagnostic, it will then be necessary to resort to the glucose tolerance test. Only in subclinical or borderline cases is this test indicated. The importance of the last statement was recently re-emphasized to me. A ten year old youngster was hospitalized for diagnosis and regulation of diabetes. Due to a misunderstanding of orders, a tolerance test was run, in spite of a fasting blood sugar of 226 mgm percent. Table III gives the results of the test. As you see, the fasting blood sugar and urine test alone were diagnostic. The test resulted in a blood sugar rise to 824 mgm percent in two hours. Acidosis was present. It took considerably larger doses of insulin to control this child, initially, than it would have taken had the excessive glucose not been given. It is unwise to subject the juvenile or any other diabetic to unnecessary episodes of hyperglycemia and acidosis.

Dr. Garfield Duncan states that "the value of this test lies in its diagnostic aid and not as an indicator of the severity of the diabetes".

If the tolerance test is necessary, careful preparation of the patient is of the utmost importance. The patient must have a normal temperature, he must be free from infection, and the diet prior to the test must, for a minimum of three days, be high in carbohydrate (300 grams). Insulin should not have been given for one week prior to the test. The conventional three or four hour test, giving 100 grams of glucose for the adult or for the child weighing over one hundred pounds is the test of choice.

Figure 2 shows the normal, mild, and more severe diabetic curves. The diagnostic levels are the same as noted previously for random blood sugar levels.

Confronted with a symptomless melituria in which blood sugar levels are normal, it is necessary to determine the reducing substance which is present. Sugar detected by the usual test is likely to be glucose but may be fructose, pentose, lactose, or very rarely galactose, maltose, mannoheptulose — following the ingestion of avocados — and sucrose. Our problem at this time is the diagnosis of diabetes mellitus. We will not concern ourselves with the job of sleuthing required in detection of these sugars. The significance, however, of the non-

Table III
RESULTS of GLUCOSE TOLERANCE TEST on 10 YEAR OLD RECENT ONSET JUVENILE DIABETIC

	Blood Sugar	*Urine*
Fasting	226 mgm %	Yellow
½ hour	412 mgm %	Yellow
1 hour	572 mgm %	Yellow
2 hours	824 mgm %	Red
3 hours	740 mgm %	Red

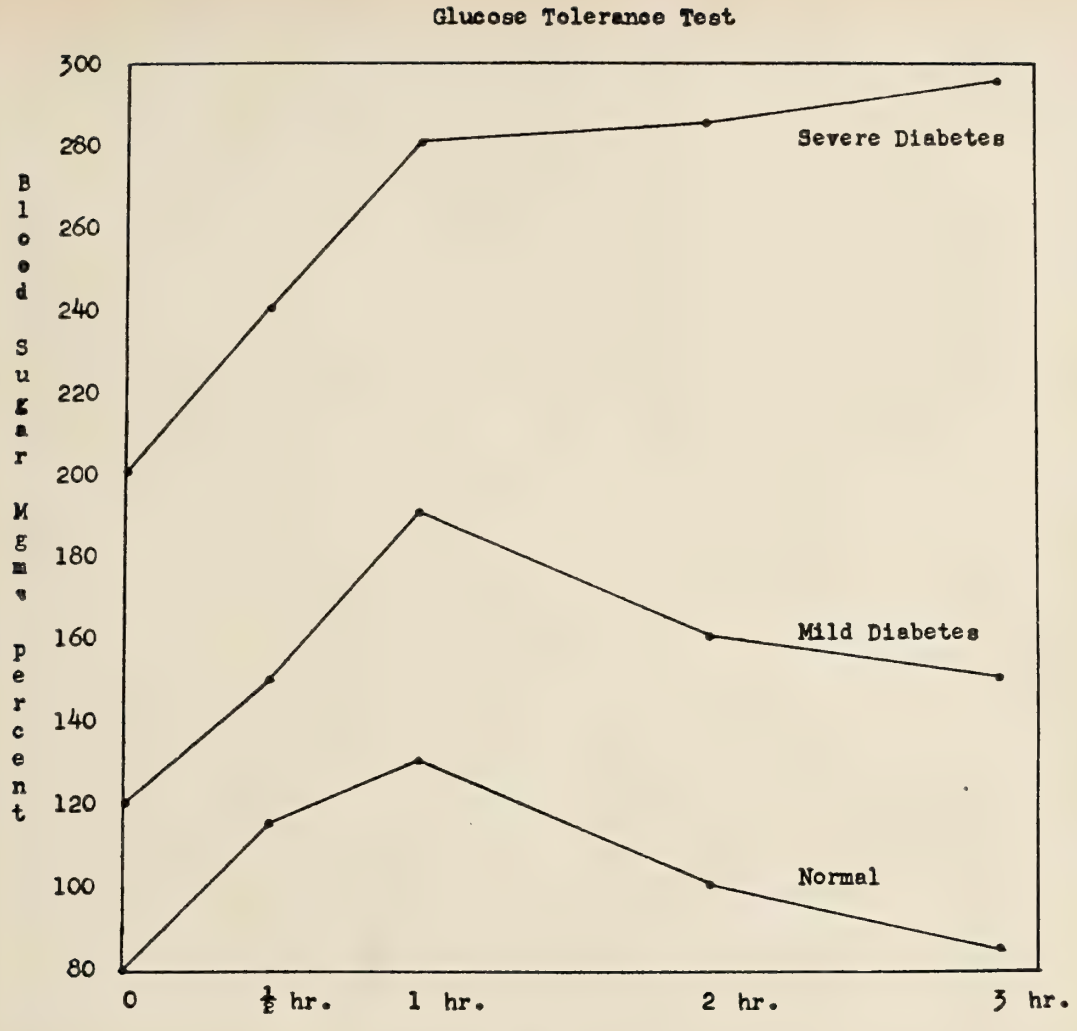


Figure 2

diabetic meliturias is three fold: "first, there is the danger that they may be mistaken for diabetes and treated with diet and insulin; second, a reducing substance especially glucose in hyperthyroidism and during pregnancy, and lactose during lactation, may be taken for granted and co-existing diabetes overlooked; third, all meliturias are clinically benign and relatively innocent except the glycosuria due to diabetes".[9]

In a consideration of glycosuria two groups deserve special mention. One of these is that of potential diabetes. This is a most unsatisfactory diagnosis. It is used for individuals with glycosuria closely related to diet, who easily become sugar free with slight restrictions, and whose blood sugar is below 130 mgm percent fasting and never reaches 170 mgm percent after a meal. These patients should be checked at intervals. They must be followed closely with constant awareness of the possibility of the development of diabetes.

The second group is that of renal glycosuria. This is an innocuous condition in which the renal threshold for sugar is extremely low. All urine specimens, even those taken after a fast, contain sugar. The blood sugar level is always normal. Among 40,000 cases of melituria seen by the Joslin group there have been only 84 cases of renal glycosuria. This condition is asymptomatic, the rate of carbohydrate utilization is normal. Treatment is not necessary. There is no tendency to progression to diabetes.[10]

Diabetes Detection Drives have been emphasized in recent years. The importance of these

Drives is obvious. Their purpose is not only the detection of new cases. They serve also in the education of laymen and physician. McLoughlin in his article published in the September 19th issue of the Journal of the American Medical Association calls attention to inadequate follow-up. He presents findings in the screening of 600,000 persons by the Georgia Department of Public Health.[11] He states that "more than 82% of the referred persons classified as non-diabetic by physicians were assured of the absence of this disease on the basis of no laboratory work at all or nothing more reliable than a urinalysis or fasting blood sugar". We should heed this warning: too many physicians are still employing a fasting blood sugar or urinalysis alone as a diagnostic procedure for diabetes.

Our discussion of recognition and diagnosis of diabetes has but little significance unless we are fully aware of the need for patient education, the need for control of this disease. The life of your ten, twenty or thirty year duration case may be one of activity and happiness. It may, on the other hand, be one of heartache and handicap.

Full realization by the physician of the benefits of good control will mean an awareness of the need for education of our patient. We look to the example of Dr. Elliott Joslin. Teach your diabetic patient all you possibly can about diabetes and he will make your task of detection that much easier. If we are aware of the symptoms and signs of diabetes, and of the need for definitive diagnostic procedures, recognition and diagnostic will assume their rightful importance.

REFERENCES

1. Saundby, R.: Diabetes Mellitus, Allbutt & Rolleston's System of Medicine, London, 1908, III. p. 167.
2. Allen, F. M.; Stillman, E.; Fitz, R.: Total Dietary Regulation in the Treatment of Diabetes, The Rockefeller Institute for Medical Research, 1919, New York.
3. Joslin, E. P.: Treatment of Diabetes Mellitus, Lea & Febiger, Philadelphia, 1952, p. 258.
4. Joslin, E. P.: Treatment of Diabetes Mellitus, Lea & Febiger, Philadelphia, 1928.
5. Joslin, E. P.: Treatment of Diabetes Mellitus, Lea & Febiger, Philadelphia, 1952.
6. Duncan, G. G.: Diseases of Metabolism, W. B. Saunders Company, Philadelphia & London, 1952, p. 788.
7. Dublin, Louis I.; Marks, H. H.: Influence of Certain Causes of Death, Human Biology, 1930, 2:159.
8. Joslin, E. P.: Treatment of Diabetes Mellitus, Lea & Febiger, Philadelphia, 1952, p. 152.
9. Duncan, G. G.: Diseases of Metabolism, W. B. Saunders Company, Philadelphia & London, 1952, p. 821.
10. Marble, A.: The Diagnosis of the Less Common Meliturias, Med. Clin. of N. America, March, 1947, p. 313.
11. McLouglin, C. J.: Petrie, L. M.; Hodgins, T. E.: Diagnostic Significance of Blood Sugar Findings, JAMA, 1953, 153, p. 182.

The General Practitioner

L. H. Johnson, M.D., Casey

A GENERAL practitioner first must be a graduate of an approved medical school who, after a specific hospital training period is capable of assuming responsibility for the following areas of medical care:

1. Diagnosis of all major and minor medical and surgical conditions (except extremely rare or complicated ones); treatment of the great majority of the conditions diagnosed but only the minor surgical conditions.

2. The practice of obstetrics to the level of uncomplicated deliveries; early recognition of abnormalities; and emergency treatment of the few unpredictable but potentially catastrophic complications that may arise in pregnancies.

3. Pediatrics to the level required for medical and surgical treatment, for recognition of the many contagious diseases, and judgment in the use of immunization against them.

4. Psychiatry to a level permitting the differentiation of serious, potentially serious, and mild psychoses and psychoneuroses, and permitting treatment of the last mentioned by intelligent support, clarification, and reassurance.

As to responsibilities in diagnosis, few will dispute the fact that internal medicine forms the basis of general practice from the point of view of diagnosis; the separation of medical and surgical conditions is arbitrary and unrealistic. The decision frequently is a matter of personal opinion, custom, convention, or prejudice. For these reasons, the fields of internal medicine and surgical diagnosis are considered together.

Functional conditions offer a large proportion of the problems confronting the general practitioner. This does not mean that they are superficial problems, undemanding of time and thorough clinical procedure. If anything, they are more demanding than problems associated with organic disease. The establishment of a sound and certain diagnosis of a functional disorder may require a more thorough physical examination, more detailed history taking, and more laboratory procedures than the establishment of a diagnosis of pernicious anemia or carcinoma of the cervix.

The general practitioner who does industrial work must have a general knowledge of each plant's operation. He ought to have a knowledge of health education, sanitation, working conditions, the prevention of accidents and occupational diseases, and preventive health measures in general. He should have a knowledge of diagnosis and treatment of occupational disease, be competent in handling traumatic lesions, versed in procedures for follow-up rehabilitation, and have a knowledge of workman's compensation laws. He must realize that his first duty is to the workman whom he examines or treats, and he should like people.

Talking with the patient is the basis of any department of the practice of medicine. Skill in this communication is as fundamental a requirement for the physician as is a knowledge of anatomy or chemistry. The family doctor of a generation ago was more than a physician. He was a friend of the family; he practiced psychiatry before it was invented; he quieted family fears when he walked through their door, after which he was able to accomplish better results with whatever treatment he recommended. If this were true a generation ago, it still is true today, and this same power or gift still is available to the physician who will cultivate it.

The general practitioner who skips the physical examination in the interest of time or economy, or who, at best, gives it only slight attention may be slighting a most serviceable tool. The general practitioner must ponder on the near relationship which obtains between the practice of medicine and the social life of the people. In

Address of the President of the Aesculapian Society of the Wabash Valley; Annual Meeting—1954.

reality they are not just simply cases; but men, women, and children, each with a separate personality, environment, and heredity, and with individual habits, training, temperament, and psychology. Therefore, the general practitioner must possess a large amount of sympathy and a liberal humanism. He must be the missionary of hygiene and the chief educator of people in the ways of health.

The future of medicine does not lie in laws now legislated or suggested for legislation. It does not lie in fact finding commissions or public opinion polls. It does not lie in public relations build-ups or government lobbies. The future of medicine lies in the patient; the patient as an individual. The physician must protect this individual, who will feel confident in having a physician sincerely interested in his welfare and health. He is in turn the guardian of the physician.

Protect the individuality of the patient, and the art of medicine will retain its most essential quality — the personal relationship between physician and patient.

« « « » » »

Read the Program
And Discover
How Informative
And Entertaining
YOUR
Annual Meeting
Will Be.

PROGRAM

One Hundred Fifteenth

Annual Meeting

Illinois State Medical Society

Hotel Sherman **Chicago**

May 17, 18, 19, 20,
1955

Program Summary

TUESDAY, May 17

In the Morning:
- Section on Anesthesiology — Room 104
- Section on Eye, Ear, Nose and Throat — Assembly Room
- Section on Cardiovascular Disease — Room 114
- Section on Obstetrics and Gynecology — Room 101
- Physicians' Association — Room 113
- FIRST MEETING OF THE HOUSE OF DELEGATES — Louis XVI Room

At noon:

In the Afternoon:
- GENERAL ASSEMBLY in the Ballroom
- Section on Radiology at 3:30 p.m. in the Crystal Room

In the Evening:
- Public Relations Dinner — Room 101
- HOSPITALITY HOUR — (9:00 p.m.) Bal Tabarin on Sixth Floor

WEDNESDAY, May 18

In the Morning:
- Women Physicians' Breakfast at 8:00 a.m. — Room 113
- Section on Surgery — Room 101
- Section on Pediatrics with Section on Preventive Medicine and Public Health — Louis XVI Room
- Section on Eye, Ear, Nose and Throat — The Assembly Room
- Section on Pathology — Room 104
- Illinois Chapter, American College of Chest Physicians — Room 114
- Meetings of the Reference Committees of the House of Delegates

At Noon:
- Luncheon for the Section on Surgery — Room 101
- Luncheon for the Section on Pathology — Room 104
- Luncheon for Illinois Chapter, American Academy of Pediatrics — Louis XVI Room
- FIFTY YEAR CLUB LUNCHEON — Assembly Room
- Luncheon — Illinois Chapter, American College of Preventive Medicine — Room 103
- Luncheon — Illinois Chapter, American College of Chest Physicians — Room 114

In the Afternoon:
- GENERAL ASSEMBLY in the Ballroom

In the Evening:
- THE ANNUAL DINNER honoring Dr. Arkell M. Vaughn, President — Ballroom

THURSDAY, May 19

In the Morning:
- Section on Allergy — Room 114
- Section on Medicine — The Assembly Room
- Section on Dermatology — Room 101
- Section on Preventive Medicine & Public Health with Section on Pediatrics — Louis XVI Room
- Meetings of Reference Committees of the House of Delegates

At Noon:
- Phi Chi Luncheon — Room 107
- Luncheon for the Section on Dermatology — Room 101
- Luncheon for the Section on Allergy — Room 104
- Luncheon for the Section on Preventive Medicine & Public Health with Illinois Association of Medical Health Officers — Louis XVI Room

In the Afternoon:
- GENERAL ASSEMBLY in the Ballroom
- SECOND MEETING OF THE HOUSE OF DELEGATES at 3:30 p.m. in Louis XVI Room

In the Evening:
- Loyola Alumni Dinner — Crystal Room
- Phi Beta Pi Smoker — Abbott Hall
- Phi Rho Sigma dinner — Chicago Illini Union

FRIDAY, May 20

In the Morning:
- THIRD MEETING OF THE HOUSE OF DELEGATES at 8:30 a.m. in Louis XVI Room
- Scientific Movies in the Crystal Room
- The meeting closes officially at noon on Friday

In the Afternoon:
- Illinois Association of Blood Banks — Louis XVI Room

An Extract from the Constitution and By-Laws

CHAPTER XIII

SECTION 3. All papers read before the Society or any Section thereof, shall become the property of the Society. Each paper shall be deposited with the Secretary when read, and presentation of a paper to the Illinois State Medical Society shall be considered tantamount to the assurance on the part of the writer that such paper has not already been published.

Meetings of the House of Delegates

THE COMMITTEE ON CREDENTIALS will meet at 8:00 a.m. on Tuesday morning, May 17, in the entrance way to the Louis XVI Room. Delegates desiring to be certified as the official representatives of their county medical societies must present their credential cards to this committee.

The Outstanding General Practitioner for 1955, H. O. MUNSON of Rushville, will be honored at the first meeting of the House of Delegates to be held on Tuesday morning, May 17, in the Louis XVI Room.

THE FIRST MEETING OF THE HOUSE OF DELEGATES

The Louis XVI Room

9:00 a.m. TUESDAY, May 17, 1955

The first meeting of the HOUSE OF DELEGATES will be called to order by the President, Arkell M. Vaughn of Chicago for:

The appointment of Reference Committees;

Reports of Officers, Councilors, Committees, etc.

Introduction of Resolutions

and for the transaction of any other business which may come before the House.

THE SECOND MEETING

The Louis XVI Room

3:30 p.m. THURSDAY AFTERNOON, May 19, 1955

The Second Meeting of the HOUSE OF DELEGATES will be called to order by the President to hear those reports which are ready to be presented.

THE THIRD MEETING

The Louis XVI Room

8:30 a.m. FRIDAY MORNING, May 20, 1955

The Third (and last) Meeting of the HOUSE OF DELEGATES will be held Friday Morning, May 20, at 8:30 a.m., in the Louis XVI Room to:

Hear those reports remaining to be presented

For the Election of Officers, Councilors, Committees, Delegates and Alternates to the American Medical Association;

and for the transaction of any other business to come before the House.

At the close of this last meeting, F. GARM NORBURY of Jacksonville, will be installed as the new President of the Illinois State Medical Society, and will receive the official gavel from the retiring President, Arkell M. Vaughn of Chicago.

Scientific Programs Scheduled for the First Day of the Meeting

Tuesday, May 17, 1955
SECTION ON ANESTHESIOLOGY

CHAIRMAN ..... Ernest F. Kreutzer, Joliet
SECRETARY ..... Arthur T. Shima, Oak Park
ALTERNATE ..... E. M. Dewhirst, Danville

TUESDAY MORNING, May 17, 1955

The Emerald Room — No. 104

9:00- 9:10 Opening — Chairman

9:10- 9:30 "Alcohol Inhalation in the Treatment of Acute Pulmonary Edema in the Immediate Post Operative Period"

RUTH WEYL, Associate Professor of Anesthesiology, Chicago Medical School; Director of Anesthesiology, Mount Sinai Hospital, Chicago

9:30- 9:50 "Reaction to Local Anesthetic Drugs"

RAYMOND F. ROSE, Clinical Instructor in Anesthesiology, University of Illinois College of Medicine, Chicago

MAX S. SADOVE, Professor of Surgery, University of Illinois College of Medicine; Head, Division of Anesthesiology, Research and Educational Hospitals, Chicago

9:50-10:10 "Anesthesia Management of the Bad Risk Patient for Transurethral Prostatic Resection"

CONSTANCE L. GRAVES, Staff Anesthesiologist, Wesley Memorial Hospital, Chicago

MARY KARP, Assistant Professor of Surgery, Division of Anesthesia, Northwestern University Medical School; Director of Anesthesiology, Wesley Memorial Hospital, Chicago

10:10-10:40 RECESS TO VIEW EXHIBITS

10:40-11:00 "General Anesthesia in Dentistry"

FRANCIS M. GREM, Associate Professor of Anesthesia, Loyola University School of Dentistry, Chicago

11:00-11:20 "Hypothermia in Vascular Surgery"

PAUL W. SEARLES, Director of Anes-

thesia, St. Luke's Hospital, Chicago
MAX S. SADOVE, Head, Division of Anesthesiology, Research and Educational Hospitals, Chicago

11:20-11:40 "Local Analgesia in General Practice"
ERNST TRIER MORCH, Professor of Anesthesiology, University of Chicago School of Medicine; Director of Anesthesia, University of Chicago Hospitals and Clinics, Chicago

11:40-12:00 Business Meeting and Election of Section Officers

SECTION ON EYE, EAR, NOSE AND THROAT

CHAIRMAN ..... Philip R. McGrath, Peoria
SECRETARY ..... Fletcher Austin, Chicago
TUESDAY MORNING, May 17, 1955
The Assembly Room

9:00- 9:20 "The Treatment of Nasal Polyposis with Hydrocortisone"
WALTER E. OWEN, Peoria

9:20- 9:30 Discussion

9:30- 9:50 "Radiation Cataract"
DAVID SHOCH, Instructor in Ophthalmology, Northwestern University Medical School, Chicago

9:50-10:00 Discussion

10:00-10:20 "Carcinoma of the Larynx, Classification, and Results of Treatment"
JOHN R. LINDSAY and Associates, Professor of Ophthalmology, University of Chicago, The School of Medicine, Chicago

10:20-10:30 Discussion

10:30-11:00 "Non-Surgical Treatment of Concomitant Strabismus"
HERMANN M. BURIAN, Professor of Ophthalmology, University of Iowa Hospitals, University of Iowa College of Medicine, Iowa City

11:00-11:15 Discussion

11:15-11:30 Business Meeting and the Election of Section Officers

---

11:30 RECESS TO VIEW EXHIBITS

SECTION ON OBSTETRICS AND GYNECOLOGY

CHAIRMAN ... Howard L. Penning, Springfield
SECRETARY ..... Charles D. Krause, Chicago
TUESDAY MORNING, May 17, 1955
Old Chicago Room — No. 101

9:00- 9:20 "Occiput Posterior"
BEATRICE E. TUCKER, Chicago

9:20- 9:40 "Office Detection of Cancer"
VINCENT FREDA, Chicago

9:40-10:00 "Hysterosalpingography in Sterility"
C. KANE ZELLE, Springfield

10:00-10:30 RECESS TO VIEW EXHIBITS

10:30-10:50 "Ruptured Uterus"
GEORGE P. VLASIS, Chicago

10:50-11:10 "Obstetrical Anesthesia"
WENDEL R. FREEMAN, Champaign

11:10-11:40 "Immediate Care of the Post-Partum Patient"
WILLIAM BENBOW THOMPSON, Clinical Professor of Obstetrics, University of California at Los Angeles, Los Angeles, Calif.

11:45 BUSINESS MEETING and election of Section Officers.

SECTION ON CARDIOVASCULAR DISEASE

CHAIRMAN ..... V. Thomas Austin, Urbana
SECRETARY .... Chauncey C. Maher, Chicago
TUESDAY MORNING, May 17, 1955
The Gold Room — No. 114

9:00 "Supraventricular Tachycardia"
ROBERT W. ELLIOTT, Alton

9:20 "Ventricular Tachycardia"
EMMETT B. BAY, Professor, Department of Medicine, University of Chicago — The School of Medicine, Chicago

9:40 "Bundle Branch Block"
FORD K. HICK, Professor of Medicine, University of Illinois College of Medicine, Chicago

10:00- RECESS TO VIEW EXHIBITS
10:30 "Auricular Fibrillation"
ROBERT L. GRISSOM, Professor of Medicine, Assistant Chairman, Department of Medicine, University of Nebraska College of Medicine, Omaha

11:15 "Auriculo-Ventricular Block"
STANLEY L. LEVIN, Danville

11:35 QUESTION AND ANSWER PERIOD
Drs. Elliott, Bay, Hick, Grissom and Levin
BUSINESS MEETING — and Election of Section Officers

PHYSICIANS' ASSOCIATION
of the
DEPARTMENT OF PUBLIC WELFARE

TUESDAY MORNING, May 17, 1955

Ruby Room — No. 113

J. W. Klapman, President ..... Chicago
H. Salomon, 1st Vice President ..... Manteno
M. Komarjanski, 2nd Vice President .... Peoria
S. J. Lipnitsky, Secretary-Treasurer ..... Dixon

9:00 a.m.

1. FURTHER REPORTS ON SCHIZOPHRENIA RESEARCH FROM MANTENO STATE HOSPITAL
   "Pharmacological Aspects"
   CARL PFEIFFER, Manteno
   "Psychiatric and Psychological Aspects"
   N. S. APTER, A. ELLERD, J. BERRY, Manteno

2. THORAZINE IN THE TREATMENT OF MENTAL ILLNESS
   Isadore Spinka, Chicago

3. A CASE OF EXTRAPYRAMIDAL SYMPTOMS FOLLOWING THORAZINE MEDICATION
   Eli Bader, Chicago

4. EDUCATIONAL THERAPY FOR MENTAL HOSPITALS
   J. W. Klapman, Chicago

SECTION ON RADIOLOGY

CHAIRMAN ..... E. Kenneth Lewis, Chicago
SECRETARY ..... Fred H. Decker, Peoria

TUESDAY AFTERNOON, May 17, 1955

The Crystal Room

3:30 p.m.

The guest moderator for the film reading session of the Section on Radiology will be WENDELL G. SCOTT, Associate Professor of Clinical Radiology, Washington University School of Medicine, St. Louis.

Following the scientific portion of the program, a business meeting and the election of Section Officers will be held.

General Assembly

The Ballroom

TUESDAY AFTERNOON, May 17, 1955

Presiding ..... Ernest F. Kreutzer, Joliet
Assisting ..... Charles D. Krause, Chicago

1:30- 1:40 OPENING OF THE GENERAL ASSEMBLY
Arkell M. Vaughn, President, Illinois State Medical Society, Chicago

1:40- 2:00 "The Dangers of Delay"
WILLIAM B. THOMPSON, Clinical Professor of Obstetrics, University of California at Los Angeles, Los Angeles, Calif.

2:00- 2:20 "Safety in Modern Anaesthetic Practice"
JOHN GILLIES, Director, Department of Anesthesia, Royal Infirmary, Edinburgh, Scotland

2:20- 2:40 "Tumors of the Thyroid"
GEORGE CRILE, Jr., Chairman, Department of Surgery, Cleveland Clinic, Cleveland, Ohio

2:40- 3:10 RECESS TO VIEW EXHIBITS

Presiding ..... Philip R. McGrath, Peoria
Assisting ..... Chauncey C. Maher, Chicago

3:10- 3:30 "The Value of Routine Radiographic Examinations in the Diagnosis of Cardiac Anomalies and Diseases"
WENDELL G. SCOTT, Associate Professor of Clinical Radiology, Washington University School of Medicine, St. Louis, Missouri

3:30- 3:50 "Recent Advances in Drug Therapy"
ROBERT L. GRISSOM, Professor of Medicine, Assistant Chairman, Department of Medicine, University of Nebraska College of Medicine, Omaha, Nebraska

3:50- 4:10 "Vascular Changes in the Eye in Hypertension and Other Pathologic Conditions"
HERMAN M. BURIAN, Professor of Ophthalmology, State University of Iowa College of Medicine, Iowa City, Iowa

Scientific Programs Scheduled for the Second Day of the Annual Meeting

Wednesday, May 18, 1955

SECTION ON EYE, EAR, NOSE AND THROAT

CHAIRMAN ..... Philip R. McGrath, Peoria
SECRETARY ..... Fletcher Austin, Chicago
WEDNESDAY MORNING, May 18, 1955
The Assembly Room

9:00- 9:20 "Some Complications of Round Pupil Cataract Surgery"
EDWARD C. ALBERS, Christie Clinic, Champaign

9:20- 9:30 Discussion

9:30-11:30 SYMPOSIUM ON MAXILLOFACIAL INJURIES
Moderator: Samuel J. Pearlman, Associate Professor of Otolaryngology, Northwestern University Medical School, Chicago

9:30- 9:50 "Nasal Fractures"
IRA J. TRESLEY, Associate in Otolaryngology, Northwestern University Medical School, Chicago

9:50-10:10 "The Treatment of Fractures of the Mandible"
ORION H. STUTEVILLE, D.D.S., M.D., Professor of Maxillofacial and Oral Surgery, Northwestern University Dental School, Chicago

10:10-10:20 Discussion

10:20-10:50 "Fractures of the Middle Third of the Face"
G. KENNETH LEWIS, Clinical Associate Professor of Otolaryngology, University of Illinois College of Medicine, Chicago

10:50-11:10 "Anaesthesia for Maxillofacial Injuries"
MAX SADOVE and Associates, Professor of Surgery (Anaesthesia), University of Illinois College of Medicine, Chicago

11:10-11:30 Discussion

11:30 RECESS TO VIEW EXHIBITS

SECTION ON PATHOLOGY

CHAIRMAN . Benjamin Markowitz, Bloomington
SECRETARY ..... Franklin J. Moore, Chicago
WEDNESDAY MORNING, May 18, 1955
The Emerald Room — No. 104

9:00-10:00 Presentation of Case Reports and Current Research Projects by Pathology Residents

"Atypical Endometrial Changes Associated with the Presence of Chorionic Tissue in the Uterus or in Ectopic Sites"
R. PILDES AND J. WHEELER, Mt. Sinai Hospital, Chicago

"Chronic Lymphocytic Leukemia Associated with Hypergammaglobulinemia"
F. BUFFA, Mt. Sinai Hospital, Chicago

"Acute Liver Necrosis Following Use of Chloramphenicol"
A. SCHNEIDER, Research and Educational Hospitals, University of Illinois, Chicago

"Postpartum Candida Infection"
J. WHITAKER, Research and Educational Hospitals, University of Illinois, Chicago

Discussion of papers

10:15-10:50 "Clinical Chemical Significance of Ionography"
H. J. McDONALD, D.Sc., Professor and Chairman, Department of Biochemistry, Stritch School of Medicine, Loyola University, Chicago
Discussion

11:00-11:20 "Differential Diagnosis of Medical and Surgical Jaundice"
HANS POPPER, Pathologist, Cook County Hospital, Director of Hektoen Institute, Chicago
Discussion

11:30-11:50 "Recent Advances in Exfoliative Cytology"
E. A. McGREW, Assistant Professor of Pathology, University of Illinois College of Medicine, Chicago
Discussion

12:00 LUNCHEON and Annual Business Meeting — ELECTION OF SECTION OFFICERS
Business meeting of Illinois Society of Pathologists
Luncheon will be held in the same room — No. 104

Illinois Chapter

AMERICAN COLLEGE OF CHEST PHYSICIANS

WEDNESDAY MORNING, May 18, 1955
The Gold Room — No. 114
First Floor

PANEL DISCUSSIONS

9:15-12:00 noon.

1. HOME CARE OR INSTITUTIONAL CARE OF PULMONARY TUBERCULOSIS
   ABEL FROMAN, Consultant in Tuberculosis, Manteno State Hospital, Manteno
   ROBERT LEVITT, Assistant Professor, Department of Medicine, University of Illinois College of Medicine, Chicago
   M. R. LICHTENSTEIN, Medical Director, Municipal Tuberculosis Sanitarium, Chicago

---

2. RECENT EXPERIENCES IN DIAGNOSIS AND TREATMENT OF CARDIOVASCULAR DISEASE
   Moderator: BENJAMIN M. GASUL, Director, Pediatric Cardio-Physiology Department, Cook County Children's Hospital, Chicago
   ROBERT F. DILLON, Associate-Attending Physician, Cook County Children's Hospital, Chicago
   EGBERT H. FELL, Attending Surgeon, Cook County Children's Hospital, Chicago
   CARL J. MARIENFELD, Associate-Attending Physician, Pediatric Cardiophysiology Department, Cook County Children's Hospital, Chicago

12:00 Luncheon and business meeting

OFFICERS:

Clifton Hall, President ..... Springfield
Albert H. Andrews, Jr., Vice-President and Acting Secretary ..... Chicago
Kenneth C. Johnston, Program Chairman .. .. Chicago

The LUNCHEON will be served in the same room — The Gold Room, No. 114

LUNCHEON
Illinois Chapter
AMERICAN COLLEGE OF CHEST PHYSICIANS
Wednesday noon, May 18
The Gold Room — No. 114
First Floor

SECTION ON PEDIATRICS

CHAIRMAN .... Ralph H. Kunstadter, Chicago
SECRETARY ..... J. Keller Mack, Springfield

THE SECTION ON PREVENTIVE MEDICINE & PUBLIC HEALTH has been invited to participate in this combined meeting.

WEDNESDAY MORNING, May 18, 1955
Louis XVI Room

9:00- 9:20 "The Diagnosis and Management of Rheumatic Fever in Children"
JOSEPH R. CHRISTIAN, Associate Professor in Pediatrics, Stritch School of Medicine of Loyola University, Alternate Attending Physician, LaRabida Sanatorium, Chicago

9:20- 9:40 "Malignancies in Childhood"
ROBERT EASTON, Methodist Hospital, and St. Francis Hospital, Peoria

9:40-10:00 "Retrolental Fibroplasia"
UDELL THIMSEN, Christian Welfare Hospital, East St. Louis

10:00-10:30 RECESS TO VIEW EXHIBITS

10:30-11:30 Panel on IMMUNITY AND ANTIBIOTICS
"Natural and Acquired Immunity"
CLIFFORD GRULEE, Jr., Associate Professor of Pediatrics and Assistant Dean, Tulane University, Louisiana School of Medicine, New Orleans.
"Artificial Immunity"
WINSTON H. TUCKER, Director of Public Health, City of Evanston
"Antibiotics as Related to Immunity"
MARK LEPPER, Associate Professor of Medicine, University of Illinois College of Medicine, Chicago

11:30 BUSINESS MEETING and the Election of Section Officers

LUNCHEON
Illinois Chapter — AMERICAN ACADEMY OF PEDIATRICS
WEDNESDAY NOON, May 18, 1955
Louis XVI Room

SECTION ON SURGERY

CHAIRMAN .... Howard P. Sloan, Bloomington
SECRETARY .... Cornelius M. Annan, Chicago

WEDNESDAY MORNING, May 18, 1955
The Old Chicago Room — No. 101

9:00- 9:15 "Common Urologic Problems in Children"
I. KEITH NEECE, Decatur

9:15- 9:30 "Pitfalls in the Management of Colles' Fracture"
JUSTIN C. McNUTT, Bloomington

9:30- 9:45 "Breast Lumps and Their Treatment"
LOUIS P. RIVER, Clinical Professor of Surgery, Stritch School of Medicine of Loyola University, Chicago

9:45-10:00 "The Use of Blood and Plasma in the Surgical Patient"
J. GARROTT ALLEN, Professor of Surgery, University of Chicago, The School of Medicine, Chicago

10:00-10:30 RECESS TO VIEW EXHIBITS

10:30 PANEL — GASTRO INTESTINAL BLEEDING
Moderator — Howard P. Sloan, Bloomington

10:30-10:40 "Prevention and Treatment of Massive Esophogeal Bleeding"
JOHN T. REYNOLDS, Clinical Associate

Professor, Department of Surgery, University of Chicago, The School of Medicine, Chicago

10:40-10:50 "Present Day Management of Bleeding Lesions of the Stomach and Duodenum"
ROBERT E. BOWEN, Springfield

10:50-11:00 "Bleeding from the Bowel"
J. C. THOMAS ROGERS, Carle Hospital Clinic, Urbana

11:00-11:10 "Physiological Consequences of Gastrointestinal Bleeding"
HAROLD LAUFMAN, Associate Professor, Department of Surgery, Northwestern University Medical School, Chicago

PANEL DISCUSSION

11:45 BUSINESS MEETING and the election of Section Officers

LUNCHEON
SECTION ON SURGERY
WEDNESDAY NOON, May 18, 1955
The Old Chicago Room — No. 101

General Assembly

The Ballroom
WEDNESDAY AFTERNOON, May 18, 1955
Presiding ..... Howard P. Sloan, Bloomington
Assisting ..... Cornelius M. Annan, Chicago

1:30- 1:50 THE PRESIDENT'S ADDRESS — ARKELL M. VAUGHN, President, The Illinois State Medical Society, Chicago

---

1:50- 2:20 THE ORATION IN SURGERY — "The Present Day Concepts in the Treatment of Venous Thrombosis"
ALTON OCHSNER, William Henderson Professor of Surgery, Chairman of the Department of Surgery, Tulane University — Louisiana School of Medicine, New Orleans

---

2:20- 2:50 THE ORATION IN MEDICINE — "Virus Problems in Medicine"
THOMAS FRANCIS, Jr., Professor and Chairman of Epidemiology, Virus Laboratory, University of Michigan School of Public Health, Ann Arbor, Michigan

2:50- 3:15 RECESS TO VIEW EXHIBITS

Presiding ..... Ralph H. Kunstadter, Chicago
Assisting ..... Herbert Ratner, Oak Park

3:15- 4:30 PANEL ON POLIOMYELITIS
Moderator: Julius H. Hess, Chicago

"Poliomyelitis Vaccine" — THOMAS FRANCIS, Jr., Ann Arbor, Michigan

"Status of Irradiated Poliomyelitis Vaccine"
HOWARD J. SHAUGHNESSY, Ph.D., Director, Division of Laboratories, Illinois Department of Public Health and
ALBERT M. WOLF, Director, Michael Reese Research Foundation, Chicago

"The Practicing Physician's Role in the Control of Poliomyelitis"
LEONARD M. SCHUMAN, Associate Professor of Public Health, University of Minnesota Medical School, Minneapolis

"Practical Aspects of Diagnosis and Care of Poliomyelitis"
CLIFFORD GRULEE, Jr., Assistant Dean, Pediatric Department, Tulane University — Louisiana School of Medicine, New Orleans

Scientific Programs Scheduled for the Third Day of the Annual Meeting

Thursday, May 19, 1955
SECTION ON ALLERGY

CHAIRMAN ..... Max Samter, Chicago
SECRETARY ..... Ellis Canterbury, Peoria

THURSDAY MORNING, May 19, 1955
The Gold Room — No. 114

9:00 "The Symptomatic Therapy of Bronchial Asthma"

A PANEL DISCUSSION — Milton M. Mosko, Moderator

"The Routine of Bronchial Asthma Control"
LEON UNGER, Associate Professor of Medicine, Northwestern University Medical School, Chicago

"Positive Pressure Breathing, Cough Stimulation and Oxygen Therapy"
GEORGE A. SAXTON, Jr., Director, Respiratory Center, University of Illinois College of Medicine, Chicago

"Inhalation Therapy of Bronchial Asthma"
MILTON M. MOSKO, Clinical Associate Professor of Medicine, University of Illinois College of Medicine, Chicago

---

10:00 "Breathing Exercises" — A Demonstration

AUDREY EVANS DeRANGO, A.B., R.P.T., Staff Physical Therapist, Department of Physical Medicine and Rehabilitation, University of Illinois College of Medicine, Chicago

10:30-11:00 RECESS TO VIEW EXHIBITS

11:00 "Reactions to Drugs"

A SYMPOSIUM — Adolph Rostenberg, Jr., Moderator

Participants:

LEONARD H. HARRIS, Peoria

NORMAN B. ROBERG, Associate Professor of Medicine, University of Illinois College of Medicine, Chicago

ADOLPH ROSTENBERG, Jr., Professor of Dermatology, University of Illinois College of Medicine, Chicago

PAUL L. WERMER, Secretary, Committee on Research, and Assistant Secretary, Council on Pharmacy and Chemistry of the American Medical Association, Chicago

LUNCHEON

SECTION ON ALLERGY

THURSDAY NOON, May 19, 1955

The Emerald Room — No. 104

SECTION ON MEDICINE

CHAIRMAN .... George Mason Parker, Peoria

SECRETARY ..... Jacques M. Smith, Chicago

THURSDAY MORNING, May 19, 1955

The Assembly Room

9:00 PANEL ON RENAL FAILURE

DAVID P. EARLE, Chicago — Moderator

JAMES A. SCHOENBERGER, Instructor in Medicine, University of Illinois College of Medicine, Chicago

J. KENNETH SOKOL, Wesley Memorial Hospital, Chicago

DAVID P. EARLE, Chicago

10:00 RECESS TO VIEW EXHIBITS

10:30 "Uncommon Sites of Herpes Zoster"

F. GARM NORBURY, The Norbury Sanatorium, Jacksonville

10:50 "Cortisone Therapy of Acute Thyroiditis"

ROBERT M. HOYNE, Urbana

11:10 "The Diagnostic Approach to the Patient with Anemia"

STEVEN O. SCHWARTZ, Professor of Hematology, Chicago Medical School, Chicago

11:30 BUSINESS MEETING and election of Section Officers

SECTION ON PREVENTIVE MEDICINE AND PUBLIC HEALTH

CHAIRMAN ..... R. F. Sondag, Murphysboro

SECRETARY ..... Herbert Ratner, Oak Park

THE SECTION ON PEDIATRICS has been invited to participate in this combined meeting.

THURSDAY MORNING, May 19, 1955

Louis XVI Room

9:00 PANEL ON SCHOOL HEALTH AND THE FAMILY PHYSICIAN

Chairman: L. L. Fatherree, Joliet

George L. Drennan, Jacksonville

James Gillespie, Urbana

Edward M. Thompson, Clinton

10:20 Intermission

10:30 "The Extent and Depth of the Retrolental Fibroplasia Problem"

ARLINGTON KRAUSE, Professor of Ophthalmology, University of Chicago School of Medicine, Chicago

11:00 "The Recognition of Streptococcal Infections in the Prevention of Rheumatic Fever and Acute Glomerular Nephritis"

ALAN C. SIEGEL, Winnetka

11:30 "The Public Health Aspects of Breast-Feeding"

HERBERT RATNER, Associate Clinical Professor of Preventive Medicine and Public Health, Stritch School of Medicine, Loyola University; Health Commissioner, Oak Park

12:00 BUSINESS MEETING and the election of Section Officers

LUNCHEON

SECTION ON PREVENTIVE MEDICINE AND PUBLIC HEALTH

with the

ILLINOIS ASSOCIATION OF MEDICAL HEALTH OFFICERS

Thursday Noon, May 19, 1955

Louis XVI Room

SECTION ON DERMATOLOGY

CHAIRMAN ..... Hans M. Buley, Champaign

SECRETARY ..... Malcolm Spencer, Danville

THURSDAY MORNING, May 19, 1955

The Old Chicago Room — No. 101

9:30 Chairman's Address: "The Dermatologist's Role in Medicine"

HANS M. BULEY, Christie Clinic, Champaign

9:45 "Skin Eruptions Caused by or Aggravated by Sunlight"

OTTO C. STEGMAIER, Jr., Moline

Discussant: Ralph W. E. Wise, Springfield

10:05 "The Role of the Tranquilizing Drugs (Thorazine and Rauwolfia Derivatives) in Dermatology"

THEODORE CORNBLEET, Clinical Pro-

fessor of Dermatology, University of Illinois College of Medicine, Chicago
SIDENY BARSKY, Chicago
Discussant: Matthew J. Brunner, Chicago

10:30 RECESS TO VIEW EXHIBITS

11:00 PANEL — "The Management of the Superficial Fungous Infections"
MODERATOR: Francis E. Senear, Professor Emeritus, Department of Dermatology, University of Illinois College of Medicine, Chicago
The members of the PANEL will consist of the Chairmen of the Departments of Dermatology from all the medical schools in Chicago.
Kodachromes of exemplary cases will be presented for discussion. Management will be stressed.
FRANCIS E. SENEAR, Moderator, University of Illinois College of Medicine
STEPHEN ROTHMAN, University of Chicago School of Medicine
HERBERT RATTNER, Northwestern University Medical School
CLEVELAND J. WHITE, Stritch School of Medicine, Loyola University
DAVID M. COHEN, Chicago Medical School

12:00 BUSINESS MEETING and election of Section Officers

LUNCHEON
SECTION ON DERMATOLOGY
Thursday Noon, May 19, 1955
Room 101

General Assembly

The Ballroom
THURSDAY AFTERNOON, May 19, 1955

Presiding ..... George Mason Parker, Peoria
Assisting ..... Malcolm Spencer, Danville

1:30- 1:50 "Allergy and the Specialties"
SAMUEL M. FEINBERG, Professor of Medicine, Northwestern University Medical School, Chicago

1:50- 2:10 "The Dermatologist's Role in the Treatment of Skin Cancer"
HENRY E. MICHELSON, Professor of Dermatology, University of Minnesota Medical School, Minneapolis

2:10- 2:30 "Interpretation of the Routine Blood Count"
KEITH TRUEMNER, Rockford Memorial Hospital, Rockford

2:30- 3:00 RECESS TO VIEW EXHIBITS

Presiding ..... Max Samter, Chicago

Scientific Programs Sched uled for the Fourth Day of the Annual Meeting

MEDICAL MOTION PICTURE PROGRAM
Friday Morning, May 20, 1955
The Assembly Room
Mezzanine Floor

8:30- 9:01 "Technique for Cholecystectomy and Common Duct Exploration"
Prepared by JOHN L. MADDEN, M.D., New York

A standard operative technique in a typical case is depicted, including diagnostic points of importance, and preoperative and postoperative cholecystograms. Significant features are a demonstration of anatomic relationships of vessels and ducts in the gallbladder region and examples of various types of gallbladder calculi according to the classification of Aschoff. Color, sound, 31 minutes.

9:02- 9:30 "Principles of Fracture Reduction
Prepared by the Veterans' Administration

This film discusses certain principles, such as early reduction, neutralization of displacing muscle pulls, countertraction, and suspension, and shows application of principles to reduction of fractures in a farmhouse situation where modern equipment is not available. Color, sound, 29 minutes.

9:32- 9:50 "Gout and Gouty Arthritis"
Prepared by JOHN H. TALBOTT, M.D., Buffalo and ALEXANDER GUTMAN, M.D., New York

This film demonstrates current knowledge in the history, etiology, and diagnosis and treatment of gout and gouty arthritis with particular reference to the uricosuric agent, Probenecid. Color, sound, 18 minutes.

9:51-10:24 "Surgery of the Aged"
Prepared by ERWIN SCHMIDT, M.D., Madison, Wisconsin

Indications for and types of operation are discussed for nine cases including gangrene with diabetes; arteriosclerosis; trauma; Buerger's disease; single and multiple amputation; amputation for carcinoma of the face and neck; pharyngoesophageal diverticulum; and carcinoma of the esophagus with Maydle gastrostomy. Color, sound, 33 minutes.

10:25-10:53 "Ovarian Tumors"
Prepared by HERBERT E. SCHMITZ, M.D., Chicago

This film demonstrates the more common benign and malignant tumors in situ and after removal. It stresses the points of differential diagnosis so important at the operating table. Color, sound, 28 minutes.

10:54-11:19 "Management of Obesity"
Prepared by NORMAN JOLLIFFE, M.D., New York

This is a lecture type film presenting Dr. Jolliffe's views on the subject of obesity. Methods of diagnosis and the dietetic management of obese patients are discussed. This film is especially suitable for the doctor in general practice. Black and white, sound, 25 minutes.

11:20-11:48 "Endometriosis"
Prepared by EDWARD D. ALLEN, M.D., Chicago

Designed to demonstrate the gross and microscopic distribution and characteristics of the commonly encountered endometrial lesions. The medical, surgical and electrocautery treatment of these lesions are demonstrated. The conservative treatment of ovarian pathology is particularly stressed.

Assisting ..... Ellis Canterbury, Peoria

3:00- 4:30 THE STUFFED-UP NOSE — Panel Discussion
MODERATOR: MAX SAMTER, Associate Professor of Medicine, University of Illinois College of Medicine, Chicago
A. L. AARONSON, Assistant Professor of Medicine, (Allergy) The Chicago Medical School, Chicago
MARC HOLLENDER, Associate Professor of Psychiatry, University of Illinois College of Medicine, Chicago
FRANCIS L. LEDERER, Professor of Otolaryngology and Chairman of the Department, University of Illinois College of Medicine, Chicago

The Illinois Association of Blood Banks

FIFTH ANNUAL MEETING
Friday Afternoon, May 20, 1955
Louis XVI Room

2:00- 2:15 "Pediatric Considerations in a Transfusion Service"
JOSEPH D. BOGGS, Pathologist and Director of Blood Bank, Children's Memorial Hospital, Chicago

(2:15- 2:20 — Discussion)

2:20- 2:35 "Exchange Transfusion — Technique and Practical Clinical and Laboratory Considerations"
ROBERT MENDELSOHN, Pediatric Department and Exchange Transfusion Service, Michael Reese Hospital, Chicago

(2:35- 2:40 — Discussion)

2:40- 2:55 "Development of the Clearing House Blood Program in the North Central District"
PAUL VAN PERNIS, Director, Northern Illinois Blood Bank, Rockford; Chairman, North Central District Clearing House.

(2:55- 3:00 — Discussion)

3:00- 3:15 "The Problem of Reporting Transfusion Reactions to the Blood Bank"
DONALD R. RUSS, Director of Blood Bank, Research and Education Hospitals, Chicago; Instructor in Pathology, University of Illinois College of Medicine, Chicago.

(3:15- 3:20 — Discussion)

3:20- 3:35 "Diagnosis of Hemolytic Transfusion Reactions"
FRANK TROBAUGH, Director of Blood Bank, Presbyterian Hospital, Chicago

(3:30- 3:40 — Discussion)

3:40- 3:55 "Donor Recruitment in Hospital and Private Blood Banks"
MISS MILDRED DeLONG, M.T., A.S.C.P., Chief Blood Bank Technician, Ravenswood Hospital, Chicago

(3:55- 4:00 — Discussion)

4:00- 5:00 ANNUAL BUSINESS MEETING AND ELECTION OF OFFICERS

Social Affairs — Luncheons — Dinners

TUESDAY, May 17, 1955

PUBLIC RELATIONS DINNER — The Crystal Room

HOSPITALITY HOUR — The Bal Tabarin — Sixth Floor at 9:30 p.m.

WEDNESDAY, May 18, 1955

Women Physicians' Breakfast at 8:00 a.m. in The Ruby Room — No. 113

Luncheon for the Section on Surgery — The Old Chicago Room — No. 101

Luncheon for the Section on Pathology — The Emerald Room — No. 104

Luncheon for the Illinois Chapter, American Academy of Pediatrics — Louis XVI Room

Luncheon for the Illinois Chapter, American College of Preventive Medicine, The Jade Room — No. 103

Luncheon — Illinois Chapter, American College of Chest Physicians — Room 114

Speaker: Lt. Col. Claude M. Eberhart, Officer, Preventive Medicine, Fifth Army Headquarters, Chicago

"Military Preventive Medicine"

Business session will follow the luncheon and program

THE FIFTY YEAR CLUB LUNCHEON — The Assembly Room

THE ANNUAL DINNER — The Ballroom

The speaker this year will be CLARENCE MANION, Former Dean of the Law School of Notre Dame University, South Bend, Indiana

The dinner will honor the retiring President — ARKELL M. VAUGHN of Chicago. The immediate Past President, Willis I. Lewis of Herrin will preside

THURSDAY, May 19, 1955

Phi Chi Medical Fraternity Luncheon — Room 106

Luncheon for the Section on Dermatology — Old Chicago Room — No. 101

Luncheon for the Section on Allergy — The Emerald Room — No. 104

Luncheon for the Section on Preventive Medicine and Public Health with the Illinois Association of Medical Health Officers — The Louis XVI Room

THE LOYOLA ALUMNI DINNER — The Crystal Room

Phi Beta Pi Smoker — Will be held at Abbott Hall, 710 North Lake Shore Drive, Chicago — to show the alumni the fraternity's new quarters. 7:30 p.m. — Abbott Hall — 8th Floor Lounge. Transportation will be provided for those desiring it from the hotel to the Smoker. Further information will be published later.

PUBLIC RELATIONS DINNER

TUESDAY EVENING, May 17, 1955

The Crystal Room
First Floor

6:30 p.m.

The Public Relations Dinner will be held for the third consecutive year. Any member of the Illinois State Medical Society interested in public relations and the many phases presented in this important field, will be most welcome at the dinner.

The program is specifically planned by the Committee on Medical Service and Public Relations to bring to the responsible officers of county medical societies, secretaries, public relations chairmen or others, some ideas on their basic importance in the public relations program of organized medicine.

PROGRAM

CHAIRMAN . . Percy E. Hopkins, M.D., Chicago
Chairman, Committee on Medical Service and Public Relations.

THE FELLOWSHIP HOUR

TUESDAY EVENING, May 17, 1955

The Bal Tabarin
6th Floor

9:00 p.m.

The dinners held on Tuesday evening should all adjourn by 9:00 o'clock so that the physicians attending the 1955 annual meeting may take part in the Fellowship Hour scheduled for the Bal Tabarin.

All the technical exhibitors will be invited to join with the physicians again this year; the local Technical Exhibit Committee has been given the responsibility of extending the invitation from the Illinois State Medical Society to the representatives of the commercial houses to join with the physicians again this year in making this an evening of fun and entertainment.

The Society is the host for the evening.

COME AND GET ACQUAINTED!

WOMEN PHYSICIANS' BREAKFAST

WEDNESDAY MORNING, May 18, 1955

The Ruby Room — No. 113
First Floor

8:00 a.m.

On Wednesday morning, May 18, the Women Physicians registered at the annual meeting will be the guests of the Illinois State Medical Society at a breakfast meeting.

This annual breakfast has been held for several years, and the women physicians in attendance have enjoyed a complimentary breakfast and short

and informal program before the scientific programs for the day open at 9:00 a.m.

FIFTY YEAR CLUB LUNCHEON
WEDNESDAY NOON, May 18, 1955
Assembly Room
Mezzanine

12:15 p.m.

Andy Hall, Chairman of the Fifty Year Club since its formation in 1937, will preside again this year at the annual complimentary luncheon honoring the members of the Fifty Year Club.

The luncheon will be held the second day of the meeting this year. All physicians who have been in the practice of medicine for fifty years or more will be guests of the Illinois State Medical Society at one of the most popular social functions held during the annual meeting of the Society.

All members of the Fifty Year Club are invited to attend.

Tickets for the luncheon are complimentary and may be secured at the ticket desk during the first day of the meeting, or from Doctor Hall.

Illinois Chapter
AMERICAN ACADEMY OF PEDIATRICS
WEDNESDAY NOON, May 18, 1955
Louis XVI Room
First Floor

The Illinois Chapter, American Academy of Pediatrics, will have its annual meeting in conjunction with the annual meeting of the Illinois State Medical Society on Wednesday noon, May 18, immediately following the scientific program of the SECTION ON PEDIATRICS.

This will be a luncheon meeting and will be held in the same room as the morning scientific session, thereby facilitating a shift of Academy activities.

The luncheon will be an open meeting. All physicians and their wives are cordially invited to attend.

Illinois Chapter
AMERICAN COLLEGE OF PREVENTIVE MEDICINE
WEDNESDAY, May 18, 1955
The Jade Room — No. 103

The Illinois Chapter, American College of Preventive Medicine has made arrangements to have a luncheon meeting during the annual meeting of the Illinois State Medical Society.

12:00 noon — luncheon

1:00 — Business session

Speaker — Lt. Col. Claude M. Eberhart, Officer, Preventive Medicine, Fifth Army Headquarters, Chicago

"Military Preventive Medicine"

All physicians are welcome to attend the luncheon and are invited to the business session and program.

Physicians certified by the American Board of Preventive Medicine are especially invited, and are eligible to attend the business session if they have applied for membership.

Officers of the
Illinois Chapter, 1955

Charles F. Sutton ..... President
Jackson P. Birge ..... Vice-President
N. R. Frankovelgia ..... Secretary-Treasurer

THE ANNUAL DINNER
WEDNESDAY EVENING, May 20, 1955
7:00 o'clock
THE BALLROOM
Mezzanine

Willis I. Lewis, Immediate Past President .... Toastmaster

Invocation — The Very Rev. James T. Hussey, S.J., President Loyola University, Chicago

"The Constitution — America's Certificate of Public Health .....-CLARENCE MANION, Former Dean of the Law School, University of Notre Dame, South Bend, Indiana

---

Introduction of Past Presidents and Guests ... . Willis I. Lewis, Toastmaster

Presentation of President's Certificate
To Arkell M. Vaughn ..... By Joseph T. O'Neill, Ottawa, Chairman of the Council

Dinner Music ..... Blackstone String Ensemble
Under direction of Irving Margraff

PHI CHI FRATERNITY LUNCHEON
THURSDAY NOON, May 19, 1955

The Orchid Room — No. 106
First Floor

12:15

The Phi Chi Fraternity will have a luncheon meeting on Thursday noon, May 19, in the Orchid Room, No. 106 on the First Floor of the Hotel Sherman.

Dr. Jacob E. Reisch of Springfield, editor of the Phi Chi Bulletin, will be in charge of the plans.

All members of the fraternity are welcome to attend.

LOYOLA MEDICAL ALUMNI BANQUET
THURSDAY EVENING, May 19, 1955
The Crystal Room

7:00 p.m.

The Class of 1930 — which celebrates the twenty-fifth anniversary of its graduation this year, will be honored at the dinner. Special reunions are also being arranged for several other anniversary classes: 1925 — 30th anniversary 1935 — 20th anniversary, and 1945 — 10th anniversary.

Co-chairmen of the committee assisting with plans for the silver anniversary are Dr. Albert C. Bellini and Dr. John C. Wall.

Other features include an address by Dr. John

Sheehan, Dean of the Stritch School of Medicine of Loyola University and the presentation of an Award of Merit Medal to Dr. Warren W. Furey.

Theta Chapter
PHI BETA PI FRATERNITY
ALUMNI SMOKER
THURSDAY EVENING, May 19, 1955

Theta Chapter of PHI BETA PI will hold its annual Alumni Smoker on Thursday evening, May 19, 1955 at 7:30 p.m.

All members of Phi Beta Pi are cordially invited to attend this event which is scheduled during the annual meeting of the Illinois State Medical Society to allow the greatest number of alumni to be present.

The SMOKER will take place in the chapter lounge on the eighth floor of ABBOTT HALL, Northwestern University, 710 Lake Shore Drive, Chicago. Transportation will be provided from the hotel.

Scientific Exhibits

COYE C. MASON, Director and Chairman ... . Chicago
ARKELL M. VAUGHN ..... Chicago
DWIGHT E. CLARK ..... Chicago
LEO M. ZIMMERMAN ..... Chicago
L. W. PETERSON ..... Chicago
HAROLD L. METHOD ..... Chicago
J. C. THOMAS ROGERS ..... Urbana
EVERETT P. COLEMAN ..... Canton

Exhibit No. 1

Title: Version and Extraction.
Exhibitor: Frederick H. Falls, Charlotte S. Holt.
Institution: Illinois State Dept. of Public Health.
Description: Exhibit consists of drawings lettered charts, sculptures and x-rays depicting the technique of the various forms of version and extraction and outlining indications and contraindications with a description of the anatomy involved and maternal and fetal pathology incident to the operation.

Exhibit No. 2

Title: A New Organic Absorbent Powder Base: Clinical results in 264 Cases.
Exhibitor: Cleveland J. White.
Institution: Department of Dermatology, Stritch School of Medicine, Loyola Univ., Chicago; Hospitals: Mercy, Norwegian-American, Oak Park, West Suburban and Resurrection.
Description: This powder base is a finely processed maize. It has found to be absorbent of serum and fluids to almost ten times its own weight, doing so without decomposing or caking. At the present, there is no such powder on the market. Because of its great ability to absorb, excessive fluids (inflammatory, exudative or perspiration) are absorbed, making the powder an excellent Bacteriostatic and fungistatic agent. Exact figures are given in the research work relative to the aforementioned angle as well as clinical results obtained in these cases, most of the cases being fungus infections involving the intertriginous areas for a period of many years. Detailed charts have been made showing the results in different types of cases.

Exhibit No. 3

Title: Billroth I or Billroth II.
Exhibitor: James Graham.
Institution: Springfield Rural Urban Clinic.
Description: The Methods for joining the stomach to the intestinal canal fall into two general types, Billroth I and Billroth II. Although these terms are designations for specific surgical procedures, they are used loosely to classify variations of the original Billroth operations. Billroth devised the II operation as an expedient for difficult and emergency situations. It is easier to accomplish. Perhaps this is the reason for the wider use of Billroth II.

The Billroth I method joins stomach and duodenum in anatomic and physiologic continuity and therefore has principle to recommend it in preference to the Billroth II. The gastric content is emptied directly into the duodenum so that admixture of gastric, duodenal, biliary, pancreatic and jejunal secretions follows the natural sequence. Billroth I eliminates the possibility of retrograde filling of a closed duodenal loop and the possibility of retrograde stomal intususception of the jejunum. It reduces the chance of partial duodenal obstruction. It is probable that Billroth I has been used less frequently in the last 25 years because the ease of bringing up a jejunal loop for a Billroth II anastomosis has dulled interest in the principles of duodenal mobilization. The duodenum must be freely mobilized for a Billroth I anastomosis. With patience the duodenum can be mobilized to the extent that its proximal cut surface can be applied to the level of the diaphragm.

Exhibit No. 4

Title: Oral Pathology.

Exhibitor: A. G. Anderson, M. Marvin Weiss, I. Harris.

Institution: Veterans Administration Hospital.

Description: The scientific exhibit on Oral Pathology, V.A. Hospital, Hines, Illinois, is composed of flexichromes grouped as follows: 1) Carcinoma of the tongue: 2) Carcinoma of the floor of the mouth: 3) Photos of x-rays and flexichromes of eosinophilic granuloma, maxilla and mandible: 4) osteo-radionecrosis of teeth following maximum x-ray treatment for carcinoma of the parotid gland: 5) A pulp polyp: 6) Virus infection, oral mucosa: 7) Stevens-Johnson Syndrome: 8) Moniliasis — indiscriminate use of antibiotics: 9) Leukoplakia: 10) Chondrosarcoma, mandible: 11) Addison's Disease: 12) Leukemia: 13) Prognathos, surgical correction 14) Odontoma, Mandible.

Exhibit No. 5

Title: Surgical Treatment of Congenital Cardiovascular Anomalies.

Exhibitor: William L. Riker, Arthur DeBoer, Thomas G. Baffes and W. J. Potts.

Institution: Childrens Memorial Hospital of Chicago, Illinois.

Descriptions: Drawings and models show various types of operations for congenital anomalies.

Exhibit No. 6

Title: "Conservative Management of Diabetic Foot Complications"

Exhibitor: William L. Lowrie, W. Earl Redfern, Brock E. Brush

Institution: Henry Ford Hospital.

Description: Most foot complications are preventable by proper care of the feet. Amputation of an arteriosclerotic extremity for infection or gangrene adds stress to the opposite foot, which usually has an equal degree of circulatory impairment. By controlling infection, antibiotics permit a safe trial of conservative therapy. The results even in cases where amputation had been advised have been very encouraging. The progress under conservative therapy of gangrene, cellulitis, and suppurative foot lesions is shown in color. The detailed plan of management is given.

Exhibit No. 7

Title: EEG Abnormalities in Endocrine Disease.

Exhibitor: Joseph Condon, Dorothy Becka, F. A. Gibbs.

Institution: Veterans Administration Hospital, Hines, Illinois.

Description: It illustrates the major EEG abnormalities that occur in certain endocrine diseases.

Exhibit No. 8

Title: Inhalation Therapy.

Exhibitor: Albert H. Andrews, Jr. Edwin R. Levine, Max S. Sadove.

Institution: St. Lukes Hospital.

Description: The exhibit illustrates by colored drawings, photographs and diagrams the indications and uses of inhalation therapy as a means to restore adequate function to organs impaired by lack of oxygen, and to aid in the correction of interference with broncho-pulmonary mechanisms. The abnormal physiology and principles of therapy are illustrated for anoxia, pneumonia, heart disease, pulmonary edema, gas retention, emphysema and fibrosis, bronchial obstruction and bronchial asthma. Oxygen, helium, water, vapor, pressure breathing and bronchodilator aerosols are illustrated (Equipment is excluded).

Exhibit No. 9

Title: Rheumatoid Arthritis.

Exhibitor: Eugene F. Traut, Chester B. Thrift, Joseph E. Allegretti, H. Paul Carstens, Harriet M. Clark and Arthur R. Fisher.

Institution: Arthritis Clinic of Cook County Hospital, Hektoen Institute.

Description: The exhibit will portray rheumatoid arthritis in its entirety, all current information on this subject. A heading will show the number of patients with joint disease and give synonyms of rheumatoid arthritis. On the left side wall will be charts describing modern concepts of etiology, a description of its pathology and its clinical picture from the standpoints of symptoms, physical findings and microscopic characteristics. On the right wall, charts will describe its differentiation from other skeletal diseases, the outlook and treatment. This exhibit is aimed to fulfill the purpose of the American Rheumatism Foundation and the American Rheumatism Association: To increase the interest and knowledge of practicing physicians in an important field of joint disease. Some original research is included in the exhibit. Reprints will be available. This work was financed by the Chicago Chapter of the American Rheumatism Foundation.

Exhibit No. 10

Title: Cutaneous Tumors

Exhibitor: Julius E. Ginsberg.

Institution: Northwestern Univ. Medical School, Department of Dermatology.

Description: 8 x 10 Kodachrome pictures are mounted on 11 x 14 mats with suitable signs and inscriptions to render them of teaching value. Included are some of the common tumors of the skin, some of the unusual ones, before — during — and after Roentgen therapy. Correlation is made of some of the gross clini-

cal pictures with equal size Kodachrome photomicrographs. Most of the cutaneous tumors are demonstrated in a manner to show them several times.

Exhibit No. 11

Title: Illustrations of the Liver in Health and Disease.

Exhibitor: Frank Netter, Hans Popper.

Institution: Hektoen Institute for Medical Research of the Cook County Hospital.

Description: Colored drawings, some of them schematic, will illustrate structure and function of the liver under normal and abnormal circumstances with particular emphasis upon clinical aspects. These will especially visualize the gross and microscopic distribution of vessels and bile ducts with variations and abnormalities of the gross and microscopic changes of the liver in various diseases, and the clinical and functional significance of such features like jaundice, portal hypertension, and hepatic coma. Furthermore, the physiologic basis and clinical implications of hepatic tests and their correlation with structural changes will be depicted.

Exhibit No. 12

Title: Drugs and the Brain

Exhibitor: L. H. Rudy, H. E. Himwich, F. Renaldi, R. C. Pogge.

Institution: Galesburg State Research Hospital.

Description: The exhibit will consist of clinical evaluations of newer drugs and fundamental studies of the mechanism of action.

Exhibit No. 13

Title: Poliomyelitis Vaccine — Techniques of Evaluation.

Exhibitor: Hart E. Van Riper.

Institution: National Foundation for Infantile Paralysis.

Description: The exhibit consists of a series of self-lighted transparencies illustrating the type of data which must be collected in order to arrive at an evaluation of the effectiveness of the vaccine.

Exhibit No. 14

Title: BCG Vaccination Against Tuberculosis.

Exhibitor: Sol Roy Rosenthal, Phillip G. Rettig.

Institution: Research Foundation; Institution for Tuberculosis Research at the Univ. of Illinois; Municipal Tuberculosis Sanitarium; and Cook County Hospital of Chicago.

Description: The results of a tuberculosis control program in which BCG vaccination was a part are presented. These studies were developed and followed over a 17 year period in newborns, children and young adults. The newly developed single-dose capillaries of freez-dried BCG will be demonstrated. The use of BCG as recommended by the American Trudeau Society is outlined.

Exhibit No. 15

Title: Bronchography: Massive Injection Technique.

Exhibitor: Cesare Gianturco, George A. Miller.

Institution: Carle Hospital Clinic.

Description: A description of a technique for massive injection of opaque oil for bronchography is presented with examples.

Exhibit No. 16

Title: Certification of Medical Technologists.

Exhibitor: Ruth Drummond, Registrar.

Institution: Registry of Medical Technologists of the American Society of Clinical Pathologists.

Description: Shows function and activities of Board of Registry of Medical Technologists.

Exhibit No. 17

Title: National Blood Bank Clearing House.

Exhibitor: Ardyth Cobb.

Institution: American Association of Blood Banks.

Description: This exhibit will illustrate the mechanism of an interchange of blood and blood credits between operating Blood Banks and Regional Clearing Houses.

Exhibit No. 18

Title: Hazards of Solvents.

Exhibitor: George E. Larsen.

Institution: American Medical Association.

Description: This exhibit shows some of the solvents used daily in homes and on the job and the hazards associated with their use. Precautionary measures are suggested for the elimination of tragic results arising from the use and abuse of such preparations as benzine, alcohol, carbon tetrachloride, trichlorethylene, etc.

Exhibit No. 19

Title: Medical Counseling Clinics in Rehabilitation of Young Narcotic Addicts.

Exhibitors: Irene Sherman, Walter A. Adams, Lee Sewall, Leonidas H. Berry.

Institution: Illinois Department of Public Health, Chicago.

Description: The exhibit consists of a series of facts and figures which illustrate the experiences of the staffs of three "Medical Counseling clinics". The Clinics are located at the Neuropsychiatric Institute of the University of Illinois Medical School. The department of Neuropsychiatry, Northwestern University Medical School and The Neuropsychiatry Provident Hospital. The clinics are operated by the State Department of Public Health and were organized 3 years ago (1951) 900 patients have been

examined and have received more or less effective treatment. The experiences and tentative conclusions of psychiatrists, psychologists and social workers are described.

Exhibit No. 20

Title: Mental Health

Exhibitors: Wade T. Searles.

Institution: The Illinois Society for Mental Health.

Description: Maintains program for conservation of mental health and improvement of standards of care and treatment for the mentally ill. Works for enactment of better laws governing such care and treatment. Acts as clearing house on all subjects relating to mental health. Provides consultation services to agencies and organizations with respect to mental hygiene aspects of their programs. Offers assistance in study and evaluation of community mental health needs. Circulates pamphlets and books on mental hygiene and related subjects; publishes bulletin; cooperates with other groups in planning, organizing and conducting educational programs along mental health lines. Stimulates development of mental hygiene clinics throughout the state.

Exhibit No. 21

Title: Achieve Your Proper Weight.

Exhibitor: Thelma Pollen.

Institution: The American Dietetic Association.

Description: A shadow box exhibit stressing the importance of maintaining proper weight. Exhibit consists of illuminated shadow boxes.

Exhibit No. 22

Title: The Breast Milk Bank As A Community Project.

Exhibitors: E. Robbins Kimball; Elizabeth Jones.

Institution: Evanston Hospital Association, Junior League of Evanston, Illinois.

Description: This breast milk bank was organized for the purpose of collecting and storing breast milk so that it is always available for all premature and sick babies in the community. This bank is unique in that no remuneration is given the donating mothers, nor is there any fee charged for its use. The method of operation and the equipment used is described and demonstrated. The locations of breast milk banks in this country and throughout the world are pin-pointed on a world map.

Exhibit No. 23

Title: Direct Services of The Illinois Easter Seal Society.

Exhibitor: Charles H. Moody; Mrs. Elizabeth Jameson.

Institution: Illinois Association For the Crippled, Inc.

Description: Portrays direct services given crippled children and adults.

Technical Exhibitors

	Booth
Abbott Laboratories, North Chicago	110
A. S. Aloe Company, St. Louis, Missouri	2
American Hospital Supply Corp., Evanston	98
Audio Digest Foundation, Glendale, Calif.	33
Baby Development Clinic, Chicago	3
Baker Laboratories, Inc., Cleveland, Ohio	102
Baxter Laboratories, Evanston	98
Beech-Nut Packing Co., New York, N. Y.	100
Blue Cross-Blue Shield, Chicago	38, 39
Cameron Surgical Specialty Company, Chicago	56
Chicago Medical Book Company, Chicago	36
Chicago Pharmacal Company, Chicago	99
Ciba Pharmaceutical Products, Inc., Summit, N. J.	9
The Coca Cola Company, Atlanta, Georgia	14
Crib Diaper Service, Chicago	48
Daniels Surgical & Medical Supplies, Chicago	15, 16, 17
Doho Chemical Corporation, New York, N. Y.	25
Eisele and Company, Nashville, Tenn.	8
Electro Medical Equipment Co., Chicago	18
Eli Lilly & Company, Indianapolis, Ind.	95
Encyclopedia Americana, Grand Rapids, Michigan	55
Encyclopaedia Britannica, Chicago	58, 59
Executone Company, Chicago	50
Evron Co., Chicago	54
General Foods Corporation, White Plains, New York	1
H. J. Heinz Company, Pittsburgh, Penna.	64
Illinois Assn. for the Crippled, Chicago	37
Jackson-Mitchell Pharmaceuticals, Inc., Culver City, Calif.	24
The "Junket" Brand Foods, Little Falls, New York	7
Julius Schmid, Inc., New York, N. Y.	53
Lederle Laboratories Division, American Cyanamid Company, Pearl River, New York	35
J. B. Lippincott Company, Philadelphia, Penna.	62

	Booth
P. Lorillard Co., New York, N. Y.	11
M & R Dietetic Laboratories, Columbus, Ohio	61
Mead Johnson & Company, Evansville, Ind.	111
Medical Aids, Inc., Chicago	12
Medical Protective Company, Fort Wayne, Indiana	106
Miles Reproducer Co., New York, N. Y.	13
Miller Surgical Company, Chicago	112
V. Mueller & Company, Chicago	101
National Drug Company, Philadelphia, Penna.	26
Nepera Chemical Co., Inc., Yonkers, N. Y.	105
Northern Illinois Medical Service, Inc., Rockford	34
NRD Instrument Co., St. Louis, Missouri	20
Parke, Davis & Co., Detroit, Michigan	94
Parker Aleshire & Co., Chicago	5
Charles Pfizer & Co., Brooklyn, N. Y.	60
Professional Management, Bloomington	21
The Purdue Frederick Co., New York, N. Y.	109
R. J. Reynolds Tobacco Company, Winston-Salem, N. C.	32
A. H. Robins Company, Richmond, Virginia	108
J. B. Roerig & Company, Chicago	28
Sanborn Company, Cambridge, Mass.	4
Sandoz Pharmaceuticals, East Hanover, New Jersey	27
W. B. Saunders Company, Philadelphia, Penna.	104
Schering Corporation, Bloomfield, N. J.	57
Schick X-Ray Company, Inc., Chicago	22
G. D. Searle & Co., Chicago	65
Sharp & Dohme, Philadelphia, Penna.	96
Sherman Laboratories, Detroit, Michigan	107
Smith, Kline & French Laboratories, Philadelphia, Penna.	6
E. R. Squibb & Sons, New York, N. Y.	97
Universal Products Corporation, Norristown, Penna.	49
Upjohn Company, Kalamazoo, Michigan	103
United States Tobacco Co.	52
Varick Pharmacal Company, New York, N. Y.	51
Vitamin Products Company, Milwaukee, Wis.	23
Winthrop-Stearns, Inc., New York, N. Y.	10
The Zemmer Company, Inc., Pittsburgh, Penna.	63

The firms represented here desire and deserve a visit to their exhibit by all attending the Annual Meeting.

1955 CONVENTION HIGHLIGHTS
WOMAN'S AUXILIARY
to the
ILLINOIS STATE MEDICAL SOCIETY
May 17, 18, 19

Welcome to the twenty-seventh annual meeting of the Woman's Auxiliary to the Illinois State Medical Society. We hope that this meeting will stimulate interest, give you a better understanding of the goals toward which we are striving, bring you new acquaintances, and a happy reunion with old friends.

The purposes of the State Convention are:

1. To review and appraise work of the past year on both State and County levels;
2. To decide on the programs and projects to be undertaken during the coming year;
3. To devise plans of organizing and financing such undertakings, and to choose the leaders to carry on the work.

The Convention Chairman, Mrs. Darrell H. Trumpe and her Co-Chairman, Mrs. George Pastnack, join me in hoping that you will participate in both the business sessions and social functions, and we wish you a pleasant stay in Chicago.

MRS. ALBERT KWEDAR, President

PRECONVENTION SCHEDULE
MONDAY, MAY 16, 1955

1:00-4:00 p.m. Registration — Mezzanine, Hotel Sherman

NOTE: All Board Members and Delegates arriving on Monday please register on that date.

2:00 p.m. Pre-Convention Board Meeting — Jade Room No. 103.

TUESDAY, MAY 17, 1955

8:30 a.m.—4:00 p.m. Registration — Mezzanine

8:30 a.m. County Presidents and Councilors please report at the front of the Crystal Room.

Mrs. Albert Kwedar, presiding.

Invocation — Rev. William Flaherty.

Pledge to the Flag — Mrs. W. J. Wanninger, Past President

Auxiliary Pledge — Mrs. J. P. Simonds, Editor of the Bulletin, and author of the pledge.

Welcome — Mrs. Leonard Houda, President, Woman's Auxiliary to the Chicago Medical Society

Response — Mrs. Harold Shinall, President, Woman's Auxiliary to McLean County Medical Society

Business Session:

Credentials and Registration — Mrs. Gregory Carey

Convention Rules of Order — Mrs. Arthur Mohaupt, Parliamentarian

Adoption of Convention Program

Appointment of Reference Committees

Appointment of Reading Committees

Appointment of Committee on Courtesy and Resolutions

Address: Mrs. George Turner, President, Woman's Auxiliary American Medical Association, El Paso, Texas.

Convention Announcements — Mrs. Darrell Trumpe

Presentation Promptness Award — Mrs. George Pastnack

County Presidents present: THIS IS YOUR AUXILIARY.

Time Keeper — Mrs. Warren J. Klopsch

1:00 p.m. Fashion Luncheon honoring Past Presidents

Sarah Siddon's Walk — Ambassador East Hotel

Chairman — Mrs. Henry Christiansen, Immediate Past President.

WEDNESDAY, MAY 18, 1955

8:30 a.m. to 4:00 p.m. Registration — Mezzanine

8:00 a.m. to 9:00 a.m. Coffee hour honoring Members at Large — Crystal Room

Mrs. Fred Sheehan, Chairman

9:30 a.m. Second Delegate Session — Crystal Room

Mrs. Albert Kwedar, Presiding

Presentation Promptness Award — Mrs. George Pastnack

Credentials and Registration — Mrs. Gregory Carey

Introduction of Program — Mrs. Darrell Trumpe

Film — SCHOOL HEALTH IN ACTION —John L. Reichert, M.D., in charge of discussion

Panel — FACTS AND FALLACIES ABOUT THE LEGISLATIVE PROGRAM

OF THE MEDICAL ASSOCIATION
Jacob E. Reisch, M.D., Moderator — Springfield Councilor — Fifth District, I.S.M.S.
Mr. Joseph Stetler — Mr. James C. Leary
Symposium — "An Auxiliary in its Lair Is a Turtle or a Hare"
Presented by the members of the Woman's Auxiliary Sangamon County Medical Society

1:00 p.m.-4:00 p.m. Reference Committee — Mrs. Harlan English, Chairman, Vice President, Woman's Auxiliary to the American Medical Association Room 107

1:00 p.m. Reference Committee No. 1
Reports of Officers and Directors, Mrs. Joseph S. Lundholm, Chairman

2:00 p.m. Reference Committee No. 2
Reports of Standing Committees, Mrs. Charles Lesage, Chairman

3:00 p.m. Reference Committee No. 3
Reports of Councilors, Mrs. S. M. Hubbard, Chairman
Guests are welcome at all Reference Committee Meetings

7:00 p.m. ANNUAL DINNER honoring Dr. Arkell M. Vaughn, retiring President of the Illinois State Medical Society.

THURSDAY, MAY 19, 1955

9:30 a.m. Third Delegate Session — Crystal Room
Mrs. Albert Kwedar presiding
Presentation Promptness Award — Mrs. George Pastnack
Credentials and Registration — Mrs. Gregory Carey
Reports of Reference Committees:
Reference Committee No. 1 — Mrs. J. S. Lundholm
Reference Committee No. 2 — Mrs. Charles Lesage
Reference Committee No. 3 Mrs. S. M. Hubbard
Courtesy and Resolutions — Mrs. James McDonnough, Past President
Report of Nominating Committee — Mrs. S. M. Hubbard
Election of Officers
New Business
Memorial Service — Mrs. Carl Sibilsky, Editor of Illinois Auxiliary News, and Past President

1:00 p.m. Luncheon — Assembly Room on Mezzanine Foor Honoring Mrs. Albert Kwedar, President Mrs. Warren Young, President-Elect
Invocation — Rev. Joseph A. George, Director, Evangelical Hospital, Chicago
Introduction of Guests at Speakers' Table — Mrs. Albert Kwedar
Introduction of Luncheon speaker — H. Kenneth Scatliff, M.D.
Guest Speaker: ALPHONSE McMAHON, M.D., Immediate Past President, Southern Medical Association, St. Louis, Missouri
Subject: "THE DOCTOR AND THE PUBLIC"
Installation of Officers — Mrs. Harlan English
Luncheon Chairman — Mrs. Maurice Hoeltgen Co-Chairman — Mrs. Leonard Houda

4:00 p.m. Post-Convention Board Meeting — Old Chicago Room 101
Mrs. Warren Young, presiding.

EDITORIALS

The Annual Secretaries' Conference

The Annual Secretaries' Conference of the Illinois State Medical Society was held at the Hotel Leland, Springfield, on Sunday, March 27, 1955. The weather was bad, and the attendance somewhat lowered for this reason. However, there were 130 registered for the meeting, representing county medical societies from all parts of the state. The officers of the Secretaries' Conference had arranged a program of general interest to society officers and other members of the state medical society.

Jacob E. Reisch, Councilor of the Fifth District and a resident of Springfield, opened the meeting, and introduced the Chairman for the Conference, Lee N. Hamm of Lincoln. Louis R. Limarzi was the first speaker on the regular program, discussing "Long Range County Medical Society Program Planning". Dr. Limarzi, as chairman of the Scientific Service Committee, which aids county societies in arranging their scientific programs, and of the Committee on Post Graduate Education, has had much experience in program planning, and he gave many good suggestions for the proper arrangement of programs at the county level.

Mr. Edward J. Holman, Attorney and Staff Associate in the Legal Department of the A.M.A. discussed "Trends in Malpractice", giving a most interesting presentation on this important subject. Walter C. Bornemeier of Chicago talked on "Medical Ethics", a subject in which he has been greatly interested over a period of years. A question and answer period followed this presentation.

"The Illinois Public Aid Commission" was considered by the Executive Secretary of the I. P. A. C., Mr. Garrett W. Keaster, and by Burtis E. Montgomery of Harrisburg, Chairman of the Illinois State Medical Society Advisory Committee to the I. P. A. C. This was an interesting hour, and many of the current problems relative to care of the public assistance recipients were discussed.

The state society was host at a complimentary luncheon and during the luncheon Doctor Arkell M. Vaughn, president of the state society, gave a short talk, and Dr. James H. Hutton told of the work connected with the development of the History of Medical Practice in Illinois covering the period from 1850 to 1900. The book should be off the press before the Annual Meeting in May, and quite a number present gave orders for the book.

Dr. Joseph T. O'Neill, Chairman of the Council, told of the current controversy concerning the procedure to be followed in administering polio vaccine to children in the first and second grades.

Mrs. Albert T. Kwedar, Springfield, as president of the Woman's Auxiliary to the Illinois State Medical Society, gave an interesting and informative address on the work of the organization, their problems, aims and objectives. Dr. Russell Roth of Erie, Pennsylvania talked on the subject "Putting New Members to Work". Dr. Roth as a member of the Board of Trustees of his own state society, a member of the Committee on Federal Medical Service of the A. M. A. and long time Secretary of the Erie County Medical Society, has a background

which enabled him to give a fine discussion of the subject.

Mr. Leo E. Brown, Director, A. M. A. Department of Public Relations, talked on "Society Publicity Through Radio, Press and TV." He too has a background which aided materially in this presentation which was of general interest to all present.

The final subject, "The State Society Secretary's Hour" was presented by Harold M. Camp, Secretary of the State Society, Mrs. Frances C. Zimmer, the Secretary's Executive Assistant, and Mrs. Jane Zimmer Swanson, who has been in charge of the Physicians' Placement Service in the Secretary's office for the past 12 years.

Attorney Walter L. Oblinger, Associate Counsel for the State Society, was introduced, and told briefly of his work in Springfield, and of some bills which have been introduced in the Illinois Legislature of special interest to the medical profession.

Following this presentation, the nominating committee gave its report, and the following officers for the Secretaries' Conference for the coming year were elected:

Chairman — William DeHollander, Springfield.

Vice-Chairman — Norris J. Heckel, Chicago.

Secretary — E. N. DuPuy, Quincy.

The group voted unanimously to have the next annual conference in Springfield in 1956. In spite of cold and stormy weather the attendance was good and the interest excellent. Many who had expected to be present were unable to get to Springfield for the session, and it is hoped the weather man will be more friendly next year.

‹ ›

Drug reactions

Allergic drug reactions produce smooth muscle spasm and mucous membrane edema as well as urticaria and other allergic skin reactions. The majority are relieved by epinephrine, ephedrine, antihistaminic agents, cortisone acetate, or corticotropin. A reaction may appear after the drug is used for the first time but more commonly, it occurs following repeated administration. After allergy develops, minute quantities will precipitate a reaction.

But physicians may be careless in their terminology and blame allergy for symptoms resulting from toxic, pharmacodynamic, or cumulative action. Some drugs are so toxic they prove dangerous unless the patient is co-operative and reports frequently. Digitalis, curare, dicumarol, and the thiocyanates are in this group.

Reactions due to side effects of drugs also are common. These responses are regarded by Brown[1] as nontoxic and nonallergic but annoying and undesirable because they are of no value in treating the disease. The drowsiness produced by some of the antihistaminics fall into this category as well as the palpitation, tremor, and jitteriness associated with the use of Benzedrine.®

Now and then side effects of a new product are found to be desirable in treating other diseases. Thereafter, the manufacturer may recommend its use for conditions other than the original one. Thus, the drowsiness produced by certain antihistaminics has been capitalized upon and the products are sold over the counter as nonbarbituric sedatives. Amphetamines depress appetite and, during the past few years, this reaction led to the use of these drugs in the obesity regimen. The tranquilizing influence of the isonicotinic acid derivatives make them useful in managing mania.

The secondary effects of some drugs also are annoying. The best examples are symptoms accompanying changes in bacterial flora of the gastrointestinal tract by certain wide spectrum antibiotics.

An idiosyncracy is an inherent abnormal reaction to a drug. Some patients become excited rather than sleepy after taking a sedative.

The reaction due to intolerance also must be differentiated from allergy. In this state, the patient shows signs and symptoms of overdosage from minute quantities. Cinchonism may follow a dose of quinine far below the recommended levels in persons who are intolerant to this chemical.

‹ ›

Reawakening of interest in hemophilia

"Blood is a very special kind of sap"

Goethe.

A variety of conditions may cause a tendency to bleed from slight injuries, but of these hemo-

1. Brown, Ethan Allen: Problems of Drug Allergy, J.A.M.A. 157:814 (Mar. 5) 1955.

philia is perhaps the best known to the laity. The main reason for this is probably the fact that through transmission to her descendents by Queen Victoria of England the disease was a common one in several of the royal families of Europe notably the Hohenzollerns, the Battenbergs, the Romanoffs, and the Spanish Hapsburgs. While familial bleeding is mentioned in the Babylonian Talmud, it was not until 1803 that its peculiarities were clearly described by John Conrad Otto of Philadelphia.

Until recent times the chief peculiarities of hemophilia were described as: (1) its transmission by the females of a bleeder family who themselves were never bleeders, and (2) its occurrence in their male descendents. As Theodor H. Spaet (Foot Note, Spaet, T. H., Stanford Med. Bull., 1955, *13*, 24.) has shown in a recent analysis, based on the study of 247 articles on bleeders, there has been considerable progress in our knowledge of the disease in recent years.

It has been shown that hemophilia is due to a congenital deficiency of a specific clotting factor, an antihemophilic globulin. This can be isolated and studied in vitro and there is now available much information about its chemical and physical qualities and its role in the mechanism of clotting. It is possible that in hemophilia it may be deficient or else neutralized by a circulating anticoagulant.

From the genetic viewpoint it has been shown that the disease may occur spontaneously without any family history of bleeding. This was to be expected for every family disease must originate with a hereditable abnormality in a particular individual. It has also been shown that incontestable cases have occurred in females and that this is likely to occur when the parents of the bleeder are first cousins, the father a hemophiliac and the mother a carrier. However, the chance of hemophilia developing in a female is less than one in a million.

It is not sufficiently appreciated that bleeding in hemophiliacs is to some extent cyclic. A hemophiliac may at times have normal laboratory findings while at other times the deficiency of the antihemophilic globulin may be demonstrable. In periods of latency a good deal of trauma may cause but little hemorrhage. In periods of activity hemarthrosis is usually one of the prominent symptoms most frequently in the knee, elbow, ankle, wrist, hip, and shoulder in the order named. X-ray findings in the form of mere increase in joint space may be followed by cyst formation, usually associated with ankylosis. Hematomas in the pharynx, intrachranial bleeding, hemorrhages into the spinal canal, orbital hematomas with ocular evulsion, severe hemoptysis precipitated by pulmonary tuberculosis, and mesenteric hematoma simulating acute surgical lesions, are noted by Doctor Spaet as unusual and dramatic occurrences.

Surgery of any kind is a major problem in hemophiliacs during periods of activity. The extraction of teeth is the commonest operation likely to be followed by bleeding which is difficult to control. The mortality from internal surgery is 27 per cent, though major internal surgery, amputations, and removal of cataracts may be successfully accomplished. Social and emotional changes are important in some bleeders though many succeed in overcoming such psychological difficulties and are able to live useful lives.

The only really satisfactory treatment is the infusion of normal blood or its derivatives. The most satisfactory preparations are whole blood, plasma, or the fraction I of Cohn. Large daily doses are necessary, making the expense for blood and service very heavy. Occasionally resistance to transfusion develops, probably due to a circulatory antibody which neutralizes the antihemophilic factor found in normal blood. Luckily the disease is not very frequent. Doctor Spaet estimates that if the hemophiliacs were equally distributed throughout the medical profession each ten doctors would see one.

G.B.

‹ ›

J. Mather Pfeiffenberger had an interesting trip

Dr. J. Mather Pfeiffenberger of Alton, and Dr. Dewitt Handee Smith of Princeton, New Jersey spent a month in Germany as guests of the German Government on the Exchange Program. Transportation across the Atlantic by air, through the German Republic by rail, bus and air, were furnished to these selected representatives from the United States. They visited fourteen different cities, the medical departments of nine of the eighteen university hospitals in Hamburg, Frankfurt, Heidelberg, Bonn, Coln, Munich and Berlin.

This was most enjoyable as well as instructive trip, and they were able to see more in 30 days than would have been possible a few years ago in many months.

Dr. Pfeiffenberger is a Past President of the Illinois State Medical Society, and for many years, has been one of the delegates from the State Society to the American Medical Association. We hope within a short time to have a story from Dr. Pfeiffenberger for publication, telling of the trip in more detail and giving a picture of medical instruction and medical care in the West German Republic.

‹ ›

Medical reservists to receive credits for attendance at annual AMA meeting

Point credits for retention and retirement may be earned by Reserve Medical Corps officers on inactive duty who attend the Military Medical Section of the annual American Medical Association meeting to be held June 7-9, in Atlantic City, N. J., the Department of Defense announced today.

The authorization covers all eligible physicians of the Army, Navy, and Air Force Reserves. Those who attend the scientific session for more than two hours will be awarded one point credit towards retirement.

Scientific subjects of primary military importance but of interest to civilian physicians as well are scheduled for discussion by both civilian and military medical authorities. They include handicaps and motivation, automobile accidents, effects of fallout radiation, the effect on the public of breaking the sound barrier, use of whole blood in military and civil defense emergency, psychological reactions in mass casualties, and modern concepts in the treatment of burns.

‹ ›

Presidential inaugural ceremony to be broadcast

Highlights of the inauguration of Dr. Elmer Hess of Erie, Pa., as 109th president of the American Medical Association will be broadcast nationwide on Tuesday evening, June 7, during the Association's 104th Annual Meeting. The ceremonies will be held in the Ballroom of Convention Hall at Atlantic City, N.J.

An added attraction will be an address by the celebrated Norman Vincent Peale, D.D., pastor of the Marble Collegiate Church of New York City. Dr. Peale will speak on "The Relationship of Religion and Medicine."

Immediately following the formal inaugural ceremony, a reception honoring Dr. Hess will be given in the American room of the Traymore hotel.

More details on time and station of the radio broadcast will be announced later in the *Journal of the AMA*.

‹‹‹ ›››



John R. Wolff, Chairman, Walter C. Bornemeier, Edward W. Cannady, Roland R. Cross, Jr., E. F. Dietrich, W. W. Fullerton, Edwin F. Hirsch, Frederic T. Jung, W. R. Malony, Caesar Portes, William Requarth, Frederick W. Slobe.

MEDICAL CHARITIES

Roland R. Cross, Jr., Chicago

A letter to the American Medical Association for a list of charitable organizations that solicit funds from the public for health purposes brought a list of eighty. They are as follows:

NATIONAL HEALTH AGENCIES (Including Physical Handicapped)

Some of the following organizations are local in program but solicit contributions nationally, and for that reason belong in this list. However, listing here is not in itself approval or disapproval of the included organization.

Alcoholism
- National Committee on Alcoholism

Arthritis and Rheumatism
- Arthritis and Rheumatism Foundation

Blindness and Sight
- American Foundation for the Blind
- Eyes Right, Inc.
- Guide Dog Foundation for the Blind
- International Guiding Eyes
- National Braille Press
- National Brotherhood Service for the Blind
- National Council to Combat Blindness
- National Institute for the Blind
- National Society for the Blind
- National Society for the Prevention of Blindness
- New Eyes for the Needy
- Ophthalmological Foundation
- Seeing Eye, Inc.
- Sight Restoration, Inc.
- W. C. Handy Foundation for the Blind.

Cancer
- American Cancer Society
- Cancer Welfare Fund
- Damon Runyon Memorial Fund for Cancer Research
- Mechanical Research Foundation
- National Cancer Foundation
- National Cancer Hospital

Cerebral Palsy
- Cerebral Palsy Foundation
- Spastics of America
- United Cerebral Palsy Associations.

Colds
- Common Cold Foundation

Diabetes
- American Diabetes Association

Epilepsy
- Committee for Public Understanding of Epilepsy
- National Epilepsy League

Handicapped
- American Foundation of the Physically Handicapped
- Amputees Research Foundation of America
- International Society for Welfare of Cripples
- National Amputation Foundation
- National Rehabilitation Association
- National Association for Retarded Children
- National Society for Crippled Children and Adults

Hay Fever
- National Hay Fever Relief Association

Hearing
- American Hearing Society
- National Association of the Deaf

Heart
- American Heart Association

Hemophilia
- Hemophilia Foundation

Leprosy
- American Leprosy Foundation-Leonard Wood Memorial
- American Leprosy Missions

Mental Health
- National Association for Mental Health
- World Federation for Mental Health

Multiple Sclerosis
- National Multiple Sclerosis Society

Muscular Dystrophy
- Muscular Dystrophy Associations of American
- National Muscular Dystrophy Research Foundation

Nephrosis
- National Nephrosis Foundation

Nursing
- Committee for Careers in Nursing
- Frontier Nursing Association
- National Association for Practical Nurse Education
- National League for Nursing

Paraplegia
- National Paraplegia Foundation

Parenthood
- Human Betterment Association of America
- Human Betterment Federation
- Maternity Center Association
- Planned Parenthood Federation of America

Polio
- National Foundation for Infantile Paralysis
- Sister Elizabeth Kenny Foundation

Safety
- National Safety Council and others

Social Diseases
- American Social Hygiene Association

Tuberculosis
- National Tuberculosis Association

Veterans
- Disabled American Veterans
- Eastern Paralyzed Veterans Association

Miscellaneous Health
- American National Red Cross
- Foundation for the Study and Aid of the Emotionally Unstable Personality
- Health Information Foundation
- Music Research Foundation
- National Foundation for Musical Therapy
- National Fund for Medical Education
- National Health Council
- National Hospital Foundation

This list will probably increase. Robert Seaver in a recent Chicago Daily News column quoted a top professional fund raiser as saying "In the old days, charity was a virtue. Today, it's an industry." He goes on to state that the American Association of Fund-raising Counsel reports "that some 30,000,000 Americans annually give in excess of $4,000,000,000! They estimate there are some 2,800 nationwide charitable causes (many are things other than health). His column further explains how the pain is minimized in modern high pressure, well organized fund raising campaigns. "Hat-passing has become a science. And, like most sciences, it has it specialists."

At first glance at the list one is amazed at the number that exist for the same thing, such as three for cerebral palsy. It is true as we are all aware that there has been a great growth but I am sure not all are aware of the extent of that growth.

Recent publicity in New York by the New York legislature has drawn attention to some of the evils in found raising—some of the organizations were found to have spent a very high percentage of funds to pay expenses of the fund raising drive. Some organizations had large administrative overhead after the drive was over.

One hears a great deal of rumor but very little fact is brought forward to counteract it. For example, rumor has said that an organization has charged the army $35.00 a unit for blood when private blood blanks furnish blood much more cheaply in spite of the fact they have to pay donors. No facts to refute it have been publicized.

Most of these organizations utilize a lot of unpaid volunteer labor. So why should there be any administrative costs except very minimal? Should not such funds be listed so that the number of people receiving the funds be known? For example, if $100,000 is administration does it go to ten workers or one hundred? One is continually impressed by the new cars being paraded by well uniformed personnel.

At one time, much was written about banks, and later it was required by law they publish a statement of assets and liabilities. Even at present a great deal is being written and discussed as to the lack of information generally available as to how Union Health and Welfare funds are spent. Many people would like to see the light of publicity on such figures.

It is true that most medical charities have some organization that from a supervisory point of view requires a statement of income and costs —such as the Association of Commerce and Industry in Chicago. But they do not require a regular check. Usually once approved, the organization is left alone until some question has arisen about the charities' administration.

Should not these organizations be required to give more of a public accounting at regular intervals—such as before a fund drive? Are the organizations so large that an accounting statement that would list, say, $100,000, for research, might actually still mask a lot of fact? We are aware of the polio fund having spent a lot on new vaccines which are expensive and a worthy cause—but does that mean all aspects of polio funds are as worthy?

It is a difficult thing to be critical of something good for immediately and all too often the critic is labelled as being against "good." How can anyone be against "good"? But in reality nothing should become so sacred that it is above reproach or incapable of error. And, in fact, the larger it becomes, the more of an effort must be made to reach down to the level of the common man with an understandable explanation.

Let us have more light, at regular intervals, from organizations that wish funds from the generous public.

‹‹‹ ›››

Hypertension in children

We have used two of the new drugs in children with hypertension and acute nephritis. Aprescoline® was found to effect a fall in pressure in five of seven children when given parenterally. This could be maintained by continued administration. Studies of renal function revealed, however, that a decrease in renal excretory function may accompany the hypotension, and oliguria can occur. (In one instance, oliguria lasted 36 hours following two oral doses of Aprescoline.) Consequently, we feel that this agent possesses disadvantages that may outweight its beneficial effects. In our experience Bistrium® has not been effective in producing hypotension. The veratrum viride compounds have been used by others with reports of fair to good reduction in hypertension. These agents can depress renal blood flow and they must be used cautiously. *Wallace A. McCrory, M.D. Current Trends In the Management of Active Nephritis and Neophrosis in Children. Pennsylvania M.J. Feb.* 1955.

A simple idea

The progress of time seems to add more and more to the value of Harvey's discovery of the circulation of the blood yet when you read his simple statement of how he made his discovery, you wonder why it had not been done before. It occurred to him, he said, that the blood might go round, as it were, in a circle. The discovery is almost childlike in its extreme simplicity and yet it is the basis of all the exact knowledge of the processes of life which we possess today, and of all the power to prevent death which this knowledge affords us.

Sir T. Lauder Brunton.

‹ ›

What a man does with his wealth depends upon his idea of happiness. Those who draw prizes in life are apt to spend tastelessly, if not viciously; not knowing that it requires as much talent to spend as to make. *Whipple.*

CORRESPONDENCE

Annual Meeting of the Illinois Obstetrical and Gynecological Society

The Annual Meeting of the Illinois Obstetrical and Gynecological Society will be held at the Hotel Sherman, Chicago, on Monday, May 16, 1955, the day before the opening meeting of the Illinois State Medical Society.

The program will consist of a morning and an afternoon session, and all members of the Illinois State Medical Society are welcome to attend the meeting. The program has not as yet been completed, but physicians interested may receive more information by writing to Howard L. Penning, President of the Society, Springfield, Illinois.

‹ ›

Comprehensive course in industrial medicine

A full-time eight-week comprehensive course in industrial medicine for physicians will be given in the Post-Gradute Medical School of New York University-Bellevue Medical Center commencing Monday, September 26, 1955 it was announced by Dr. Norton Nelson, director of the Institute of Industrial Medicine.

Among the subjects being offered to physicians are: organization, administration, and economics of an industrial medical department; the practice of preventive and constructive medicine in industry; the clinical aspects of occupational diseases; industrial injuries and the elements of safety programs; toxicology and industrial hygiene for the physician. Opportunities will be provided for attendance at medical, surgical and clinical pathological conferences during the course.

Applications should be sent to the Dean, NYU Post-Graduate Medical School, New York 16, N.Y. Tuition $250.

‹ ›

U. of I. alumni meeting

The Medical Alumni Association of the University of Illinois School of Medicine will hold its annual banquet Monday, May 16, in the Walnut Room of the Bismarck Hotel, Chicago. Cocktails will be served at 6 p.m. and dinner at 7 p.m. Guests of honor will be Dr. Francis E. Senear, head of the department of dermatology, and Miss Margaret M. Bates, assistant librarian of Quine Library. Class reunions will be held during the banquet. Please make reservations immediately by mail; address Dr. Michael H. Streicher, 840 South Wood St., Chicago 12. Tickets are $7.50 each.

The guest speaker at the banquet will be Dr. Donald J. Caseley, medical director and assistant dean of Research and Educational Hospital.

‹ ›

Emge will deliver Bacon Lecture

Dr. Ludwig A. Emge, San Francisco, Calif., will deliver the annual Charles Sumner Bacon Lecture at 1 p.m., May 18 at the University of Illinois College of Medicine, 1853 W. Polk St., Chicago.

Dr. Emge's subject will be "The Effect of Aging Upon the Incidence of Survival from Cancer of the Female Reproductive Organs." He is clinical professor emeritus in the Department of Obstetrics and Gynecology at Stanford University School of Medicine.

The Bacon Lectureship, sponsored annually by the Department of Obstetrics and Gynecology, was set up in honor of Dr. Charles Sumner Bacon when he became professor emeritus of ob-

stetrics and gynecology at the University of Illinois College of Medicine in 1927.

‹ ›

Ninth lecture on "Treatment in Psychiatry"

The ninth lecture in the Fifth Annual North Shore Health Resort Lecture Series on "Treatment in Psychiatry — II" will be held June 1, 1955, at which time Jacob E. Finesinger, M.D., Professor and Head, Department of Psychiatry, University of Maryland School of Medicine, Chief Psychiatrist, University Hospital, Baltimore, will speak on "The Effect of Psychiatric Treatment upon the Patient's Goals."

All physicians are cordially invited to attend this lecture given at our hospital at 8:00 p.m. There is no admission charge.

‹ ›

Clinics for crippled children listed for June

Seventeen clinics for Illinois' physically handicapped children have been scheduled for June by the University of Illinois Division of Services for Crippled Children. The Division will count 11 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social and nursing service. There will be 4 special clinics for children with rheumatic fever and 2 for cerebral palsied children.

Clinics are held by the Division in cooperation with local medical and health organizations, both public and private. Clinicians are selected among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or may want to receive consultative services.

The June clinics are:

June 1 — Rock Island (Cerebral Palsy), Foss Home, 3808 — 8th Ave.

June 1 — Hinsdale, Hinsdale Sanitarium

June 7 — Fairfield, Fairfield Memorial Hospital

June 9 — Springfield, St. John's Hospital

June 9 — Elmhurst (Rheumatic Fever), Memorial Hospital of DuPage County

June 10 — Chicago Heights (Rheumatic Fever), St. James Hospital

June 14 — Peoria, Children's Hospital

June 14 — E. St. Louis, Christian Welfare Hospital

June 15 — Chicago Heights, St. James Hospital

June 22 — Springfield (Cerebral Palsy), Memorial Hospital

June 22 — Elgin, Sherman Hospital

June 23 — Rockford, St. Anthony's Hospital

June 23 — Bloomington A.M. (General), P.M. (Cerebral Palsy), St. Joseph's Hospital

June 24 — Chicago Heights (Rheumatic Fever), St. James Hospital

June 28 — Peoria, Children's Hospital

June 28 — Effingham (Rheumatic Fever), St. Anthony's Hospital

June 28 — Salem, Masonic Temple

‹ ›

Ophthalmologists of the Americas to meet in Santiago, Chile, in 1956

Ophthalmologists of the Western Hemisphere will assemble for the Fifth Pan American Congress of Ophthalmology in Santiago, Chile, January 9 to 14, 1956, under the presidency of Dr. Moacyr E. Alvaro, of Sao Paulo, Brazil.

Thirty or more eye specialists from the United States will take part in the program, which is to include symposiums on the following topics: glaucoma, collagen diseases, strabismus, detachment of the retina, tumors of the eye, plastic surgery, physiopathology and surgery of the crystalline lens, tropical diseases affecting the eye, psychosomatic diseases, visual fields and neuro-ophthalmology.

Moderators for the symposiums which will have from four to ten speakers each, will include the following from the United States: Drs. John McLean and Algernon B. Reese, New York; Peter Kronfeld, Daniel Snydacker and Derrick Vail, Chicago, and A. Edward Maumenee, San Francisco. Those from other countries of the hemisphere will be: Drs. Jorge Valdeavellano, Lima, Peru; Feliciano Palomino Dena, Mexico City; Humberto Escapini, San Salvador, El Salvador; Juan Verdaguer and Alberto Gormaz, Santiago, Chile; Durval Prado, Sao Paulo, Brazil; A. Magin Diez, Manuel Oribe, and Esteban Adrogue, Buenos Aires, Argentina.

The Pan American Association of Ophthalmology, which was founded in 1939, now has some 1500 members representing all the twenty-two countries of the Western half of the world. Its first congress was held in Cleveland in 1940

under the sponsorship of the American Academy of Ophthalmology and Otolaryngology. As interest grew rapidly in the new organization, it was decided that interim meetings would be advantageous. The first of these took place in Miami Beach, Florida, in 1950, in cooperation with the National Association for the Prevention of Blindness (U. S.) The second was held on a Caribbean cruise in January 1953, with scientific sessions on shipboard and at various ports of call with local groups of ophthalmologists. The third interim congress was in Sao Paulo in June 1954 as an official event of the celebration of the four hundredth anniversary of the founding of the city.

Each member country of the association is represented by a vice president, except the United States, which has two: Drs. William L. Benedict, Rochester, Minnesota, and Derrick Vail, Chicago. There are two secretaries: for countries north of Panama, the secretary is Dr. Thomas D. Allen, Chicago (Dr. Daniel Snydacker, 109 North Wabash Avenue, Chicago, is acting secretary at present), and for countries south of Panama, Dr. Jorge Balza, Buenos Aires.

‹ ›

American proctologic society annual meeting

The 54th Annual Meeting of the American Proctologic Society will be held at the Hotel Statler, New York City from June 1-4, 1955, it is announced by A. W. Martin Marino, M.D., of Brooklyn, N.Y., President of the nation's oldest specialty society in the field of proctology. All meetings are open to the medical profession.

Sessions on Wednesday, June 1st will feature lectures on basic sciences by distinguished authorities including:

Henry T. Randall, M.D., Clinical Director of the Memorial Hospital-Sloan Kettering Division of Cornell University Medical School Discussing: "General Principles of Water and Electrolyte Balance in Gastro-Intestinal Tract Surgery."

Benjamin G. Shafiroff, M.D., Associate Professor of Clinical Surgery, N.Y.U. Medical School discussing: "Autonomic Nervous System of Colon and Rectum."

E. A. Rovenstein, M.D., Professor of Anesthesia, N.Y.U. Medical School discussing: "The Pharmacaecology of Legal Anesthetic Agents."

Frank L. Meleny, M.D., Professor of Clinical Surgery, College of Physicians and Surgeons, Columbia University discussing: "The Rationale For The Prophylactic And Therapeutic Employment of Antibiotics as an Adjunct to Surgery Of The Alimentary Tract."

Other featured speakers include: Herman Steinberg, M.D.; Parker Vanamee, M.D.; Herbert S. Kupperman, M.D.; Arthur Purdy Stout, M.D.; Maurice M. Righter, M.D.; and Ernest W. Lampe, M.D.

From Thursday, June 2nd to Saturday, June 4th technical papers by members and guest speakers will be presented. These reports have been selected by the Program Committee whose Chairman is Dr. Norman D. Nigro of Detroit, Michigan.

The American Proctologic Society was founded in 1899 and now has more than 550 members, the largest organization in its specialty field in the world.

‹‹‹ ›››

NEWS of the STATE



ADAMS

Society News.—Dr. Harry A. Oberhelman, professor and chairman of the Department of Surgery, Stritch School of Medicine of Loyola University, Chicago, addressed the Adams County Medical Society at the Lincoln-Douglas Hotel, March 14, on "Medical Conditions of the Small and Large Bowel —Indications for Surgical Intervention."

Mental Health Association Organized.—The Adams County Mental Health Association has been organized. Presently there are 125 paid members. The Association is planning two major functions, (1) public education on mental health and (2) establishment of a Mental Health Center for treatments and educational activities. The projects have received the approval of the Adams County Medical Society, according to the Quincy Medical Bulletin. At the business meeting of the Society, official action was taken to appoint its Mental Health Committee, comprising Dr. George Borden, Chairman, Dr. Robert C. Murphy and Dr. Julius P. Schoenebaum, to serve as Advisory Committee to the new Association.

COOK

The Evolution of Medicine.—The Chicago Medical School opened a series of lectures on the Evolution of Medicine April 5. The series will be presented by Ilza Veith, Ph.D., assistant professor of the History of Medicine, University of Chicago. The first lecture was titled "The Dawn of Medicine." Others in the series are: April 12, "Greek Medicine"; April 19, "Medieval Medicine"; April 26, "Renaissance Medicine"; May 3, "The Beginnings of Modern Medicine"; May 17, "Modern Medicine." Dr. Veith, who studied medicine in Geneva and in Vienna, is said to be the only person in the United States ever to have received a doctorate in the field of History of Medicine which she received from Johns Hopkins University in 1947. In addition to her position at the University of Chicago, she is president of the Society of Medical History of Chicago and consultant in Far Eastern Medicine to the Surgeon General's Office, Washington, D. C. She is the author of "The Yellow Emperor," "Medicine at the University of Chicago," and "Perspectives in Physiology," plus some 25 articles dealing with medical history.

The Kretschmer Memorial Lecture.—Mario Stefanini, established investigator of the American Heart Association and associated professor of medicine, Tufts College Medical School, Boston, delivered the Twelfth Edwin R. Kretschmer Memorial Lecture of the Institute of Medicine of Chicago, at the Drake Hotel, April 11. This was a joint meeting of the Institute of Medicine and the Chicago Pathological Society. Dr. Stefanini's subject was "The Impact of Immunologic Concepts in Modern Hematology."

The Joseph Capps Prize.—The Institute of Medicine of Chicago is offering an annual prize of $300 for the most meritorious investigation in medicine or in the specialties of medicine. The prize will be called the Joseph A. Capps Prize and has been established by Dr. and Mrs. Edwin R. LeCount. The investigation may also be in the fundamental sciences, provided the work has a definite bearing on some medical problem. Competition for 1955 is open to graduates of Chicago medical schools who completed their internship or one year of laboratory work within a period of five years prior to January 1, 1955, excluding their terms of service in the Armed Forces. Manuscripts must be submitted to the Secretary of the Institute of Medicine of Chicago, 86 East Randolph Street, Chicago 1, not later than December 31. The manuscript of the prize paper, as submitted, is to become the property of the Institute of Medicine of Chicago. The prize winner may be invited by the Board of Governors of the Institute to present his paper at a meeting of the Institute. If no paper submitted is deemed worthy of the prize, the award may be withheld at the discretion of the Board of Governors.

Society News.—At a meeting of the Chicago Neurological Society, April 12, the following spoke: Dr. I. Diamond on "The Temporal Lobes and Auditory Pattern Discrimination in the Cat;" Dr.

D. Symnes, "Multi-Sensory Timing Ability in Individuals with Lesions of the Temporal Lobe;" "Dr. W. C. Halstead, "Some Fronto-Temporal Lobe Relationships;" Dr. L. Amador, "Surgical Aspects of Temporal Lobectomy in Man;" Dr. M. Simmel on "Psychological Findings After Temporal Lobectomy in Man" and a discussion by Dr. Percival Bailey. — The Chicago Rheumatism Society was addressed March 30 by Dr. Ben L. Boynton, medical director, Rehabilitation Institute of Chicago, on "Preliminary Report on the Use of Ultra-sound in the Therapy of Arthritis." Dr. Charles W. Denko and Dr. Delbert M. Bergenstal spoke on "Sjogren's Syndrome." — The North Shore Branch of the Chicago Medical Society was addressed April 5 at the St. Francis Hospital, Evanston, by Dr. Peter C. Kronfeld on "Current Ophthalmologic Problems;" Dr. Robert W. Keeton, "Acute Rheumatic Fever in Young Adults;" Dr. John J. Fahey, "Common Types of Tenosynovitis Involving the Hand;" and Dr. Hans von Leden on "Orbital Mucoceles (motion Pictures)"

Gift to Children's Memorial Hospital.—The Martha Washington Home for Crippled Children recently presented a check for $12,000 to Children's Memorial Hospital, it was reported in the newspapers. $10,000 will, it was said, be used for equipping one of five new orthopedic operating rooms in the hospital. The remainder will be used for care of orthopedic patients. The Home plans to donate an additional $10,000 annually for the next five years and $5,520 in the next six years to meet the cost in building and equipping the new operating rooms, it was reported.

Lecture on psychiatry.—Dr. Louis B. Shapiro, member of the staff of the Institute for Psychoanalysis, Chicago, discussed "The Need for Limits to Permissiveness" in the series sponsored by the North Shore Health Resort, April 27. This annual lecture series is on "Treatment in Psychiatry."

Douglas Vollan Named Dean of Chicago School.—Dr. Douglas B. Vollan has been appointed Dean of the Chicago Medical School, effective April 1. Dr. Vollan, assistant secretary of the Council on Medical Education and Hospital of the American Medical Association will be responsible for the academic program of the Chicago Medical School which enrolls a class of seventy-two medical students each year. For teaching purposes it is associated with Mount Sinai, Cook County, Michael Reese, West Side Veterans Administration Hospitals, the Chicago Maternity Center and La Rabida Sanitarium. While serving as assistant secretary of the Council on Medical Education and Hospitals of the American Medical Association, Dr. Vollan also served as consulting secretary of the Inter-American Foundation for Postgraduate Medical Education.

Tribute in Honor of Dr. Fischmann.—A special birthday testimonial tribute to the late Dr. Egon W. Fischmann was held Sunday, March 20, in the nurses' auditorium of Grant Hospital. Dr. Morris Fishbein, formerly editor of Journal of the American Medical Association, was principal speaker. The Dr. Egon W. Fischmann Memorial Foundation of Grant Hospital, sponsors of the program, was organized six months ago to perpetuate the memory of the medical pioneer who served thousands of Chicagoans during his 40-year career at Grant and County Hospitals, newspapers report. Dr. Fischmann died in June 1954 at the age of 70. The purpose of the Foundation is to raise funds for an addition to Grant Hospital and provide care for charity cases.

New York Physician Comes to Northwestern.—Dr. Gene H. Stollerman, medical director of Irvington House, Irving-on-Hudson, New York, has been chosen to direct research in rheumatic fever in the Department of Medicine of Northwestern University Medical School. The research program was made possible by the income from a $500,000 endowment providing for the research on a permanent basis through the Samuel Sackett Foundation for the study of rheumatic fever and its related diseases. The Foundation was created by Mr. Sackett, his wife, Shelton Reid Sackett, and daughter, Elizabeth Sackett Croker, of Houston. Dr. Stollerman will begin research at Northwestern July 1 with laboratory facilities provided in the new Morton Medical Research Building.

Plan a Unique Garden for the Blind.—The Chicago Tribune described a unique garden that is being planned to help the blind explore the wonders of the plant world. According to the report by Roy Gibbons in the Tribune, March 28, the flowers and shrubs in the proposed garden will be labeled in braille. In announcing the project Dr. Walter H. Theobald, president of the West Side Medical Center Commission, said the garden is contemplated as a gift from the Illinois Horticultural society of which F. A. Cushing Smith is president. The garden will form part of the landscaping for the Chicago Lighthouse for the blind, now starting construction on a $600,000 building within the center at Roosevelt Road, and Wolcott Avenue. This organization is a private charity incorporated in 1910. It trains the blind in useful occupations, helps them obtain employment, and last year supported its $310,000 budget with $299,000 in earned income from contract work performed by its sightless clients.

Dr. Sauer Honored.—Dr. Louis W. Sauer, Winnetka, was named "Man of the Year" and presented with the award signifying the event by the Sertoma Club of Evanston. The presentation was made by Thomas Barnard, president of the club, at a dinner meeting in North Shore Hotel, Evanston. Dr. Sauer, a pediatrician on the staff of Evanston Hospital, was chosen for the award because "he rendered great and distinguished service to mankind in developing the vaccine for whooping cough."

DU PAGE

April Designated as Immunization Month in DuPage County.—The County Medical Society again cooperated with the county health department. Members of the Society will cooperate where ever possible to carry out the immunization program for poliomyelitis. They will also devote free time to the immunization of 4,000 volunteer civilian defense workers in the county against smallpox, typhoid and tetanus. The materials are being furnished by the State Health Department. The work is being carried out under the direction of Dr. Elvin L. Seiderlin, County Health Officer.

LEE

University Approval for Dixon State School.—On March 17, 1955, Dr. Otto L. Bettag, State Welfare Director, announced that the Dixon State School has met qualifications required by the University of Chicago and Northwestern University, and is now approved by both Universities to offer administrative residency training for their students in hospital administration.

LIVINGSTON

Fifty-year Club Member.—Dr. C. C. Meeks, Pontiac, was inducted into the Fifty-Year Club of the Illinois State Medical Society at a meeting of the Livingston County Medical Society at the Palamar Cafe, February 24. The Fifty-Year Club insignia, a gold pin and certificate, was presented to Dr. Meeks by Dr. Joseph T. O'Neill, Ottawa, Chairman of the Council and Councilor of the Second District of the Illinois State Medical Society. Dr. O'Neill also spoke on the Blue Cross Hospital Plan. Dr. Louis Levin, Pontiac, gave a historical sketch of medicine in tuberculosis from early periods up to the modern up-to-date methods of medicine in this field. Thirty-three members and guests were present at the meeting. Dr. A. S. Hartman, who plans to join the Milwaukee County Medical Society, is being transferred to the V. A. Center at Wood, Wisconsin. Dr. A. Reischer, after spending two years as resident in urology in Louisville, Kentucky, has recently moved back to Dwight and has applied for reinstatement in Livingston County Medical Society.

SANGAMON

Society News.—Dr. J. E. M. Thompson, Lincoln, Nebraska, formerly president of the American Academy of Orthopaedic Surgeons, addressed the Sangamon County Medical at the Elks Club, March 3, on "Those Creaking Joints."

ST. CLAIR

Society News.—Dr. Barry Wood, Busch professor of medicine, Washington University School of Medicine, St. Louis addressed the St. Clair County Medical Society, March 3 in Belleville on "Antibiotic Therapy."

GENERAL

Waldemar Wickman Gets New Post.—Dr. Waldemar J. A. Wickman has been appointed Assistant Chief, Division of Hospitals, U. S. Public Health Service, U. S. Department of Health, Education and Welfare. He succeeds Dr. Clifton K. Himmelsbach, recently appointed Chief of the Division.

Memorial to Dr. Davis.—On April 20, a memorial meeting was held in the Crystal Ballroom of the Palmer House of the Society of Medical History and Chicago Medical Society in honor of the late Dr. D. J. Davis, Emeritus Professor of Medical History, University of Illinois College of Medicine. The program was based on the recently completed history of medicine in Illinois from 1850 to 1900. The speakers were Drs. Frederick H. Falls and William Mann, both of Chicago, and Thomas Kirkwood, Lawrenceville.

The Conquest of Pain.—On March 16, a new exhibit was opened at the Chicago Museum of Science and Industry which deals with the story of anesthesia. Entitled "The Conquest of Pain," the exhibit was designed under the medical direction of the American Society of Anesthesiologists and is presented in the public interest by Abbott Laboratories. The exhibit's purpose is threefold: 1. To explain the nature of pain, that is that pain is not something not to be feared but rather is nature's way of indicating danger to the body; 2. that surgery today is no longer a fearful experience to the patient; and 3. that the doctor's increasing ability to control pain and sustain life plays a major part in today's spectacular operating room accomplishments.

Eli Lilly and Students.—Members of the senior and junior classes of the University of Chicago School of Medicine visited Eli Lilly and Company March 22-24. While guests of Lilly's they inspected the Lilly Research Laboratories and toured pharmaceutical, biological, and antibiotic production facilities.

Included in the group were E. Jack Harris, senior class representative, and Arnold A. Gombiner, junior class representative.

Representing the school faculty with group were Dr. E. Trier Morch, professor in the department of surgery; Dr. Geraldine Light, assistant professor in the department of surgery; Dr. Roscoe E. Miller, instructor in the department of radiology; Dr. John P. Harrod, Jr., instructor in the department of obstetrics and gynecology; and Dr. Cornelius A. Navori, instructor in the department of obstetrics and gynecology. Some wives also were on the tour.

H. C. Snyder, Lilly representative in Chicago, accompanied the group to Indianapolis.

Dr. Watte Named Manager of V. A. Research Hospital.—Dr. Michael L. Watte has been appointed manager of the Veterans Research Hospital, Chicago, succeeding Dr. William W. Fellows, it was reported March 6. Dr. Watte came to Chicago from the Denver V. A. Hospital where he was also manager. Dr. Fellows, manager of the research hospital since September 1954, will become assistant chief

medical director for planning in the Central Veterans Administration Office, Washington, D. C. He will succeed Dr. Kelso A. Carroll, former manager of the V. A. Hospital at Hines, who is taking over the V. A. Center at Bay Pines, Florida.

Postgraduate Conferences.—The Postgraduate Education Committee of the Illinois State Medical Society, in cooperation with the staff of Mount Sinai Hospital, presented a Postgraduate Conference in East St. Louis, Illinois, April 7. The St. Clair County Medical Society acted as host. Speakers included Dr. Silas Wallk on "Contact Dermatitis: Diagnosis and Management;" Dr. Noah B. Levin on "Juvenile Diabetes;" Dr. Irving A. Friedman on "Iron-Deficiency Anemia;" Dr. Herbert S. Larkin, "The Use of Gold in Carcinoma of the Prostate;" Drs. Herbert D. Trace and Olga Haring in a panel discussion on "Pediatric Cardiology and Cardiac Surgery;" Dr. Ervin Kaplan on "Isotopes in Medicine;" and Dr. W. W. Fullerton on "Medical Organization Today."

The Postgraduate Education Committee, in cooperation with the Iowa-Illinois Central Medical Society and the staff of St. Luke's Hospital, presented a postgraduate conference in Moline, March 30, with the Rock Island County Medical Society acting as host. Speakers included Dr. Thomas J. Coogan on "Management of Coronary Artery Disease;" Dr. William S. Dye, "Indications for Surgery in Acquired Heart Disease;" Dr. Donald E. Murray, "Diagnostic Use of X-rays in Urology;" Dr. Claude N. Lambert, "Principles of Fracture Management;" and Dr. John T. Reynolds on "Repair of Common Duct Strictures." The evening speaker was Dr. Charles Higgins, Cleveland Clinic, who spoke on "The Clinical Significance of Hematuria."

The Postgraduate Education Committee, in cooperation with the faculty of the University of Chicago School of Medicine presented a conference in Centralia, March 17, with the Marion County Medical Society acting as host. Speakers included Dr. Melvin I. Klayman on "New Methods for Diagnosis of Cancer of the Gastro-Intestinal Tract;" Dr. Delbert M. Bergenstal on "Evaluation of Contemporary Drug Therapy of Rheumatoid Arthritis; "Dr. James W. Carpender, "Recent Advances in Radiation Therapy;" Dr. George L. Wied, "Practical Applications of Exfoliative Cytology to Clinical Gynecology;" and Dr. George V. LeRoy, "Management of the Bronchial Asthma." In the evening Dr. LeRoy spoke on "Medicine, 1955, a Prospective View."

The Postgraduate Education Committee in cooperation with the faculty of the University of Illinois College of Medicine presented a postgraduate conference in Springfield, April 28, with the Sangamon County Medical Society as host. Speakers and their subjects were: Drs. George Gee Jackson; "Viral Diseases of the Upper Respiratory Tract;" William R. Best; "Clinical Significance of Abnormal Hemoglobins;" John Louis; "Treatment of Lymphomas and Leukemias;" Mitchell A. Spellberg, "New Methods for Diagnosis of Cancer of Gastrointestinal Tract;" Eric Oldberg, "Headaches;" Irving E. Steck, "Evaluation of Contemporary Drug Therapy of Rheumatoid Arthritis" and Edwin J. Holman, of the Legal Department of the American Medical Association, "The Legal Aspects of Artificial Insemination."

The Postgraduate Education Committee in cooperation with the staff of Henrotin Hospital presented a postgraduate conference in Mattoon, April 14, with the Coles-Cumberland County Medical Society acting as host. Speakers and their subjects were: Drs. W. A. Gustafson, "Neck Snapping Injuries;" Roland R. Cross, Jr., "Management of Traumatic Lesions of the Urinary Tract;" Joseph D. Farrington, "Painful Shoulder Lesions;" Joseph B. Teton, "Diagnostic and Operative Use of the Culdoscope;" Edward J. O'Donovan, "Clinical Recognition and Treatmet of Cardiac Arrhythmias;" and Ford K. Hick and David Slight, "Physician and Psychiatrist Share the Care of a Few Patients."

Another conference in cooperation with the faculty of Stritch School of Medicine of Loyola University was held in Galesburg, April 20, with the Knox County Medical Society as host. Three panel discussions made up the program. The first, with Dr. George F. O'Brien serving as moderator, was on "Practical Pharmacology and Therapeutics of New Drugs." Participants were Drs. Peter J. Talso, Irving H. Strub and William B. Knapp. The second panel included Drs. John H. Isaacs on "Management of Prolonged Labor" and Chester J. Gajewski, "Treatment of Posterior Position." The third panel dealt with "Thoracic Surgery — Developments in Pulmonary and Cardiac Surgery." Dr. John L. Keeley was the moderator and participants were: Drs. Robert F. Dillon, William M. Lees, and John J. Brosnan. The evening speaker was Dr. Joseph Koczur on "Rehabilitation of Cerebral Accident Victims."

Illinois Hospital Screening Committee Enlarged.—On March 11, 1955, Governor William G. Stratton announced the expansion of the screening committee for hospital administrators for the Illinois Department of Public Welfare from five to seven members and named George K. Hendrix of Springfield, administrator of Memorial Hospital, and James R. Gersonde, Chicago, Executive Director of the Illinois Hospital Association, as the new members. The other five members are: Ray E. Brown, chairman, director of the University of Chicago Clinics and president of the American Hospital Association; Russell H. Duncan, administrator of Carle Memorial Hospital and Clinic, Urbana, and president of the Illinois Hospital Association.; Miss Myrtle McAhren, R.N., superintendent of Blessing Hospital, Quincy.; Dr. Malcolm T. MacEachern, professor of hospital administration at Northwestern University and director of professional relations for the American Hospital Association.; William H. Tenney, su-

perintendent of Illinois Masonic Hospital, Chicago.

American Red Cross Disaster Funds Exhausted; Chicago Chapter Alerted in Southern Flood.—The American Red Cross already has over-expanded its 1954-55 disaster budget and has been forced to draw on emergency funds for more than one million dollars to meet the needs of people affected by floods and storms in central states and the midsouth this month, Robert S. Ingersoll, Chicago fund chairman, reported.

"This points up the importance of full community support in the current Chicago Chapter Red Cross Fund campaign," Ingersoll said.

The Chicago Chapter has been alerted to assist in flood disaster operations in Mississippi and Tennessee, where 31 Red Cross disaster specialists are already working to give aid and comfort to flood victims, Ingersoll added. Red Cross is conducting relief operations resulting from floods, tornadoes, or other windstorms in eight other states, Ohio, Indiana, West Virginia, Kentucky, Alabama, Missouri, Arkansas and Michigan.

Ingersoll said the peak period of the year for disasters is just beginning. "It is the rule that serious tornadoes and floods occur during the March to June period," Bunker explained.

"It has been necessary to appropriate in excess of $5,000,000 for disaster relief, rehabilitation, and preparedness since the beginning of the fiscal year last year," Ingersoll stated. "The budget for the entire current year was set at $4,000,000, so we have had to draw a million dollars from emergency funds."

Major items in the American Red Cross disaster expenditures so far this fiscal year, Ingersoll recalled, were relief operations for victims of hurricanes Carol, Edna, and Hazel last fall, and major floods in Texas and Iowa last summer.

Local contributions made certain that Red Cross will be on the scene of disaster specialists and volunteers providing food, clothing, and shelter to the victims, Ingersoll added.

"All About Baby" on WGN-TV.—Since the last issue of the Illinois Medical Journal, the following physicians have appeared on the telecast **"All About Baby" on WGN-TV, Channel 9,** under the auspices of the **Educational Committee** of the **Illinois State Medical Society:**

Nancy Freeman, member of the obstetrical staff, Henrotin Hospital, March 23.

Sidney W. Robin, member of the pediatric staff of Michael Reese Hospital, April 6.

Charles Goldenberg, member of the pediatric staff at Michael Reese Hospital, April 13.

Lectures Arranged Through the Educational Committee of the Illinois State Medical Society:

Howard S. Traisman, Chicago, Lawn Manor Jewish Community Center Sisterhood, April 20, Behavior Problems of Adolescents.

Charles W. Schlageter, Chicago, Golda Myerson Group, Pioneer Women of Chicago, April 23, 1955, on Mental Health.

Josephine L. Earlywine, Wilmette, Washington School Parent-Teacher Association, Waukegan, April 26, on Understanding the Adolescent.

John A. Mart, Chicago, Sisterhood Niles Township Jewish Congregation in Skokie, April 14, on Live Longer and Enjoy It.

John O. Firth, Monmouth, St. Marh's Home and School Association in Canton, May 13, on Why A Case History (Physical Examination)?"

Lectures Arranged Through the Scientific Service Committee of the Illinois State Medical Society:

Fred M. Meixner, Peoria, Knox County Medical Society at the Galesburg Club, Galesburg, March 17, on Treatment of Asthma.

Jules H. Last, Highland Park, Kane County Medical Society in St. Charles, April 13, 1955, on Adaptations to Stress: Pituitary-Adrenal Relationships.

Hiram T. Langston, Chicago, Kankakee County Medical Society at the Kankakee Hotel, Kankakee, April 19, on Management of Traumatic Conditions of the Chest.

Harvey White, Chicago, Whiteside-Lee County Medical Society at Jul's Danish Farm near Rock Falls, April 21, on Pediatric Radiology.

Ormand C. Julian, Chicago, La Salle County Medical Society at the Ottawa Boat Club, Ottawa, May 12, on Arterial Diseases of the Lower Extermities.

William H. Requarth, Decatur, Iroquois County Medical Society at the Christian Church, Watseka, May 24, on Injuries of the Hand.

Lindon Seed, Chicago, Lee-Whiteside County Medical Societies at the Plum Hollow Country Club, Dixon, May 26, on Present Status of Diagnosis and Therapy of Diseases of the Thyroid.

Oglesby Paul, Chicago, Kankakee County Medical Society at the Kankakee Hotel, Kankakee, June 21, on Valvular Heart Disease: Recognition and Treatment.

DEATHS

William W. Kane*, Pinckneyville, who graduated at the College of Physicians and Surgeons, Chicago, in 1886, died January 14, aged 90, of cerebral hemorrhage.

William Clayton Mershimer*, Junction, who graduated at Rush Medical College in 1896, died January 28, aged 87, of myocarditis.

John Alexander Rusk, Tremont, who graduated at Barnes Medical College, St. Louis, in 1897, was killed February 9, aged 80, when struck by a passenger train.

Louis E. Schaeffer*, Chicago, who graduated at the Chicago Medical School in 1922, died March 29, aged 66. He had practiced medicine in Chicago for 22 years.

*Member, Illinois State Medical Society.

Arthur C. Taylor*, Chicago, who graduated at Loyola University School of Medicine in 1918, died March 29, aged 60, in Bamburg, South Carolina, while motoring home from a Florida vacation. He was a member of the staff of the Illinois Masonic Hospital, and chairman of the Ethical Relations Committee of the Chicago and Illinois State Medical Societies.

Frank P. Thompson*, Chicago, who graduated at Jenner Medical College, Chicago, in 1901, died March 26, aged 83. He had practiced medicine in Chicago for more than 50 years.

Iduma Ormond Adams, Farina, who graduated at Louisville (Kentucky) Medical College in 1898, died January 19, aged 87, of cancer.

N. Curtis Calhoun, Ashton, who graduated at St. Louis College of Physicians and Surgeons in 1909, died in Amboy Public Hospital, January 29, aged 74, of pneumonia as a result of injuries received in an automobile accident.

Alvin Vernon Cole*, Chicago, who graduated at Northwestern University Medical School in 1893, died in Virginia Beach, Virginia, January 10, aged 74. He was a member of the honorary staff of Mercy Hospital.

Roden Robinson Duff, Sr.,* retired, Chicago, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1908, died February 12, aged 77, of bronchogenic carcinoma of the lung. He was formerly a member of the faculty of the University of Illinois College of Medicine.

William F. Hewitt*, Chicago, who graduated at Rush Medical College in 1912, died March 21, aged 69. He was attending obstetrician at Illinois Central Hospital and, from 1920 to 1925, assistant professor of obstetrics at Rush Medical College.

*Member, Illinois State Medical Society.

THORAZINE*

Hydrochloride

IN SEVERE PAIN

In a study of 39 patients, Wallis found that 'Thorazine' potentiated the action of other agents to overcome acute pain, anxiety, or insomnia.

"Clinical experience with ['Thorazine'] indicates that this drug potentiates or augments the action of hypnotics, narcotics, and analgesics."

Of particular significance in cases of terminal cancer, "the concurrent use of these drugs seemed to induce a state of emotional indifference, which replaced the justified fear of death."

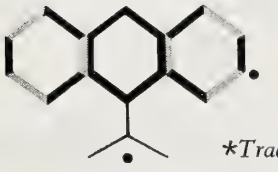
[*Wallis, R.: New York State J. Med. 55:243 (Jan. 15) 1955.*]

Available in 10 mg., 25 mg., 50 mg. and 100 mg. tablets; 25 mg. (1 cc.) ampuls and 50 mg. (2 cc.) ampuls; and syrup (10 mg./5 cc.) in 4 fl. oz. bottles.

Additional information on 'Thorazine' is available on request.

Smith, Kline & French Laboratories

1530 Spring Garden Street, Philadelphia 1



**Trademark for S.K.F.'s brand of chlorpromazine.*

Fiftieth anniversary meeting of American Trudeau Society

Three days of scientific papers, panel discussions, and special lectures on pulmonary diseases will mark the 50th anniversary meeting of the American Trudeau Society, medical section of the National Tuberculosis Association, beginning Monday, May 23, in Milwaukee, Wis. The meeting is being held in conjunction with the annual meeting of the NTA. All sessions will be in the Milwaukee Auditorium.

The chemotherapy of tuberculosis and other medical aspects of treatment, the surgical management of tuberculosis and related diseases, and current research will be discussed by specialists from all sections of the country.

Panel discussions have been arranged on the home treatment of tuberculosis; the diagnosis of fungous diseases of the lungs; the prevention, epidemiology and treatment of tuberculosis in hospital personnel; the optimal time for pulmonary resection in tuberculosis; the use of radioisotopes in thoracic disease; the future of the small sanatorium; postoperative management of pulmonary resections; the use and misuse of cortisone and corticotropin in pulmonary diseases; the management of spontaneous pneumothorax; the problem of atypical acid-fast bacilli; why patients stay in hospitals; the value of pressure breathing in the treatment of pulmonary disease; diagnostic studies in diffuse pulmonary disease, and the role of routine hospital admission X-rays.

Seven special lectures are being planned as follows: The Diagnosis and Treatment of Tuberculosis of the Bones and Joints, by Dr. Carl E. Badgley of Ann Arbor, Mich.; The Management of Chest Injuries, by Dr. N. K. Jensen of Minneapolis, Minn.; The Clinical Application of Tests of Pulmonary Function, by Dr. Giles P. Filley of Trudeau, N.Y.; The Diagnosis and Treatment of Miliary and Meningeal Tuberculosis, by Dr. Mark H. Lepper of Chicago, Ill.; The Cultivation of Tubercle Bacilli, by Dr. Emanuel Walinsky of Trudeau, N.Y.; The

(*Continued on page* 60)

Lederle

FOLBESYN*

Vitamins *Lederle*

A well-balanced, high-potency vitamin formula containing B-Complex and C

FOLBESYN provides B-Complex factors (including folic acid and B_{12}) and ascorbic acid in a well balanced formula. It does not contain excessive amounts of any one factor.

FOLBESYN Parenteral may be administered intramuscularly, or it may be added to various hospital intravenous solutions. It is useful for preoperative and postoperative treatment and during convalescence.

Dosage: 2 cc. daily. Each 2 cc. provides:

Thiamine HCl (B_1)	10 mg.
Sodium Pantothenate	10 mg.
Niacinamide	50 mg.
Riboflavin (B_2)	10 mg.
Pyridoxine HCl (B_6)	5 mg.
Ascorbic Acid (C)	300 mg.
Vitamin B_{12}	15 micrograms
Folic Acid	3 mg.

FOLBESYN is also available in tablet form, ideal for supplementing the parenteral dose.

LEDERLE LABORATORIES DIVISION AMERICAN Cyanamid COMPANY Pearl River, New York

*REG. U.S. PAT. OFF.



safe sedation

allay apprehension

eases onset of sleep



Trudeau Society (Continued)

Diagnosis and Treatment of Acute Pneumonia, by Dr. William T. Middleton of Washington, D.C., and Diagnostic Studies and Treatment of Pleural Effusions, by Dr. William W. Stead of Minneapolis, Minn.

Scientific papers at two sessions the first morning, May 23, will be on drugs used in tuberculosis treatment and on experimental studies. A session that afternoon and one Tuesday morning will be devoted to surgical subjects. At a special session Monday afternoon preliminary reports on research now underway will be presented. Approximately 40 medical exhibits will be on display.

Throughout the week there will be special entertainment for wives accompanying their husbands to the meeting. Reservation blanks for local events may be obtained by writing the National Tuberculosis Association, 1790 Broadway, New York 19, N.Y.

‹ ›

Everywhere in life the true question is, not what we have gained, but what we do.—*Carlyle*

BOOKS RECEIVED

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

HEALTH SUPERVISION OF YOUNG CHILDREN — A guide for practicing physicians and child health conference personnel. The American Public Health Association, 1790 Broadway, New York 19, New York. $2.00.

ANNALS OF THE NEW YORK ACADEMY OF SCIENCES, Vol. 59, Art. 3, "The Relation of Immunology to Tissue Homotransplantation," by J. M. Converse and 34 others. 190 pages, illustrated. Price $4.00.

ANNALS OF THE NEW YORK ACADEMY OF SCIENCES, Vol. 59, Art. 4, "Ionizing Radiation and the Cell," by L. F. Nims and 22 others. 200 pages, illustrated. Price $4.00.

AN OUTLINE OF THE TREATMENT OF FRACTURES. Revised and amplified, Fifth Edition, 1954. By the Committee on Trauma of the American College of Surgeons, 40 East Erie Street, Chicago 11, Illinois.

EARLY CARE OF ACUTE SOFT TISSUE INJURIES. First Edition, 1954. By the Committee on Trauma of the American College of Surgeons, 40 East Erie Street, Chicago 11, Illinois.

(*Continued on page 62*)

Announcing A SEMINAR ON HYPNOSIS

Intensive course on all Clinical Applications of Hypnosis
May 19, 20, 21, 22, 1955
Conrad Hilton Hotel, Chicago, Illinois

TECHNIQUES OF INDUCTION
HYPNOTHERAPY
HYPNODONTIA

Limited to Physicians, Dentists, and Clinical Psychologists

INSTRUCTORS

MILTON ERICKSON, M. D.
Psychiatry

SEYMOUR HERSHMAN, M. D.
General Practice

WILLIAM S. KROGER, M. D.
Obstetrics and Gynecology

IRVING SECTER, D. D. S.
Dentistry

WILLIAM T. HERON, Ph. D.
Clinical Psychology

FOR FURTHER INFORMATION WRITE:

Miss Pat Mc Fate, Registrar

333 North Michigan Avenue **Chicago, Illinois**

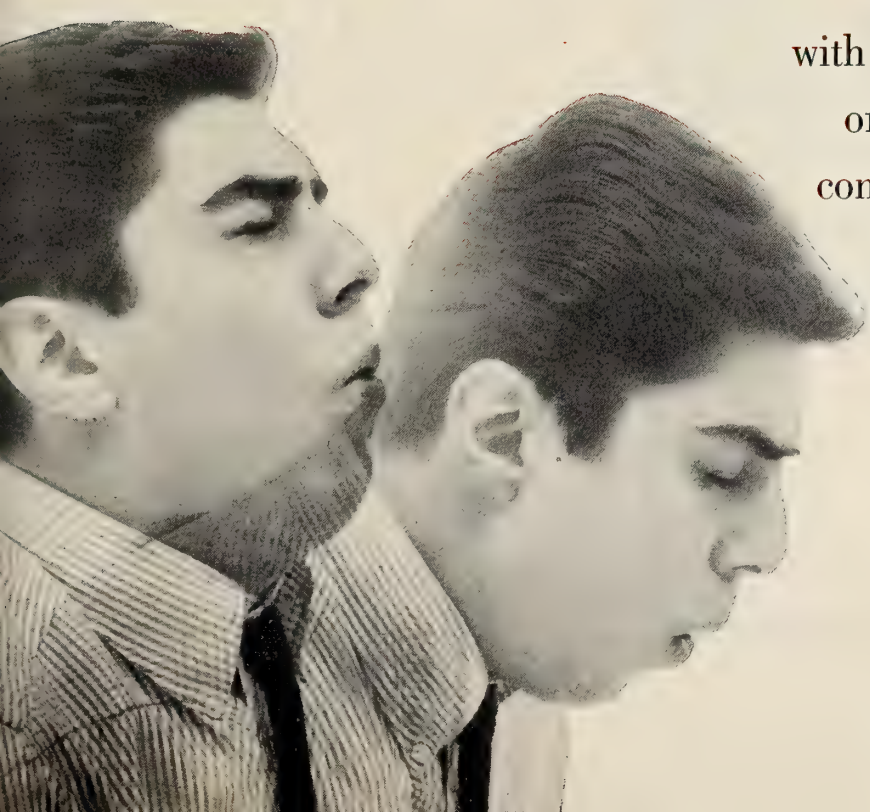
FRanklin 2-7100

Pfizer

Now...control of irritating, exhausting cough with *new*

TOCLASE*

BRAND OF CARBETAPENTANE CITRATE



without the undesirable effects associated with the usual opiates or their derivatives commonly employed in cough control.

Toclase Syrup
Bottles of one pint

Toclase Expectorant Compound
Bottles of one pint

Toclase Tablets
25 mg., bottles of 25

*TRADEMARK

PFIZER LABORATORIES
Division, Chas. Pfizer & Co., Inc.
Brooklyn 6, N. Y.

Pfizer

Edrisal*
S.K.F.'s antidepressant analgesic

for optimum results in
headache



always prescribe
2 'Edrisal' tablets per dose

Each 'Edrisal' tablet contains Benzedrine* Sulfate (racemic amphetamine sulfate, S.K.F.), 2.5 mg.; acetylsalicylic acid, 2½ gr. (0.16 Gm.); phenacetin, 2½ gr. (0.16 Gm.). Available on prescription only.

Smith, Kline & French Laboratories, Philadelphia

*T.M. Reg. U.S. Pat. Off.

BOOKS RECEIVED (Continued)

THE MEDICAL CARE OF THE AGED AND CHRONICALLY ILL. With particular emphasis on degenerative disorders, advanced cancer and other as yet incurable diseases. By Freddy Homburger, M.D., Research Professor of Medicine, Tufts College Medical School. Little, Brown and Company, Boston, Toronto. $5.75.

DOCTORS IN THE SKY — The Story of the Aero Medical Association. By Robert J. Benford, M.D., Colonel, Medical Corps, United States Air Force. Charles C. Thomas, Publisher, Springeld, Illinois. $8.75.

SEGMENTAL ANATOMY OF THE LUNGS — a study of the patterns of the segmental bronchi and related pulmonary vessels. By Edward A. Boyden, Ph.D. (Med. Sc.) Professor Emeritus of Anatomy, The Medical School, University of Minnesota. McGraw-Hill Book Company, Inc., New York, Toronto, London. $15.00.

PROGRESS IN ALLERGY. Volume IV. Edited by Paul Kallas, Helsingborg. 149 figures and 63 tables. Little, Brown and Company, Boston, Toronto. $20.00.

PERIPHERAL VASCULAR DISEASES. Authors: Edgar V. Allen, Nelson W. Barker, Edgar A. Hines, Jr., Second edition. 825 pages. 316 illustrations, 7 in color. W. B. Saunders Company, Philadelphia, London, $13.00.

A TEXTBOOK OF PHYSIOLOGY. Edited by John F. Fulton, M.D., Sterling Professor of the History of Medicine, Yale University School of Medicine, Seventeenth edition. 1275 pages. 600 illustrations. W. B. Saunders Company, Philadelphia, London, $13.50.

CHRISTOPHER'S MINOR SURGERY. Edited by Alton Ochsner, M.D., F.A.C.S., and Michael E. DeBakey, M.D., F.A.C.S. Seventh Edition. 547 pages. 251 illustrations. W. B. Saunders Company, Philadelphia and London. $9.00.

CURRENT THERAPY, 1955. Latest approved methods of treatment for the practicing physician. Edited by Howard F. Conn, M.D. 692 pages. W. B. Saunders Company, Philadelphia, London, $11.00.

MODERN TREATMENT YEARBOOK 1955. A Yearbook of Diagnosis and Treatment for the General Practitioner. Edited by Sir Cecil Wakeley, Bt., K.B.E., C.B. Published for The Medical Press by Bailliere, Tindall & Cox, LTD, London, 1955. 21st edition. $6.00

ION EXCHANGE AND ADSORPTION AGENTS IN MEDICINE—The Concept of Intestinal Bionomics. By Gustav J. Martin, Sc.D., Research Director, The National Drug Company, Philadelphia. Illustrated with 15 line drawings and 11 photographs. Little, Brown and Company, Boston, Toronto. $7.50.

PRIMARY ANATOMY. By H. A. Cates, M.B., Late Professor of Anatomy and Director of the School of Physical and Health Education, University of Toronto, and J. V. Basmajian, M.D., Associate Professor of Anatomy, University of Toronto. Third Edition. The Williams & Wilkins Company, Baltimore, 1955. $5.75.

Safer Combination Therapy

IN

HYPERTENSION

Rauwiloid® + Veriloid®

in a single tablet

Indicated in moderately severe hypertension. Each tablet contains 1 mg. Rauwiloid and 3 mg. Veriloid.

Initial dosage, one tablet t.i.d., p.c. Available in bottles of 100 tablets.

Rauwiloid® + Hexamethonium

in a single tablet

Indicated in rapidly progressing, otherwise intractable hypertension. Each tablet contains 1 mg. Rauwiloid and 250 mg. hexamethonium chloride dihydrate.

Initial dosage, one-half tablet q.i.d. Available in bottles of 100 tablets.

- SIMPLER THERAPY—Simplified dosage regimen, simplified dosage adjustment, and easier patient management.
- GREATER SAFETY—GREATER EFFICACY—Under the synergistic influence of Rauwiloid, the potent antihypertensive agents act with greater efficacy at lower, better tolerated dosages, and with notable freedom from chronic toxicity.
- BETTER PATIENT COOPERATION—In each instance, only one medication to take . . . hence easier-to-follow dosage instructions.

More Convenient for the physician . . .
Less Burdensome for the patient

Riker LABORATORIES, INC., LOS ANGELES, CALIF.

Foot-so-Port Shoe Construction and its Relation to Center Line of Body Weight



1. The highest percent of sizes in the shoe business are sold in Foot-so-Port shoes to the big men and women who have found that Foot-so-Port construction is the strongest, because .....

- The patented arch support construction is guaranteed not to break down.
- Special heels are longer than most anatomic heels and maintain the appearance of normal shoes.
- Insole extension and wedge at inner corner of the heel where support is most needed.
- Innersoles are guaranteed not to crack, curl, or collapse. Insulated by a special layer of Texon which also cushions firmly and uniformly.

2. Foot-so-Port lasts were designed and the shoe construction engineered with the assistance of many top orthopedic doctors. We invite the members of the medical profession to wear a pair — prove to yourself these statements.

3. We make more pairs of custom shoes for polio feet and all types of abnormal feet than any other manufacturer.

FOOT-SO-PORT SHOES for Men, Women, Children

There is a **FOOT-SO-PORT** agency in all leading towns and cities. Refer to your Classified Directory

Foot-so-Port Shoe Company, Oconomowoc, Wis.

Another Lederle "First"!

MUMPS VACCINE

A practical immunizing antigen for prevention of mumps in children or adults where indicated.
Immunizes for about one year.
Packages: 2 cc. vial (1 immunization),
10 cc. vial (5 immunizations).

LEDERLE LABORATORIES DIVISION
AMERICAN Cyanamid COMPANY
PEARL RIVER, NEW YORK

Lederle

Falsies preferred

The world's goods are ill distributed — too much here, not enough there. One patient will say she'd give anything to remove and hang her pendulous breasts over the foot of the bed at night; another will brood over inadequate pulchritudinous eminences. Relief for the former is relatively safe; but for the latter it is fraught with risk as it entails extraneous material. Most recent among such subtances is Ivalon®, a spongy polymer of polyvinyl alcohol with formaldehyde. Its advocates claim that it acts as a framework for living tissue, but admit it is an "excellent culture medium," difficult if not impossible to save if once infected. Among its advantages are claimed no sharp margins; no absorption; easily shaped; no complicated surgery to procure it, as in use of autogenous tissue. Furthermore, say the authors, "We strongly urge against promiscuous use of prosthesis to build up small breasts and that it never be used in cases with family history of breast cancer." If an unpredictable substance should not be used in any case, should it be used at all? Particularly in elective treatment of harmless conditions. If contour defects, large or small, unilateral or bilateral, threaten to precipitate a psychosis, introduction of an unpredictable substance and creation of a scar may merely postpone or alter its type or degree. Let us always ask ourselves the question, "Would I recommend or accept this operation upon my wife or daughter?" *Editorial. Buried Prosthesis In Soft Tissue Surgery. Rocky Mountain M.J. Jan.* 1955.

‹ ›

Smoking versus thumb sucking

Passing from the sublime to the ridiculous, the child psychologists were somewhat startled to learn that since nearly 50 per cent of normal children indulge in thumb sucking, there is not much to worry about. A child psychiatrist maintained that, to the child, thumb sucking is merely a pleasant and harmless way of passing the time until the next meal and that as a habit it deserves the same consideration as that achieved by smokers at a later age. He suggested that a well sucked thumb is much less toxic than a well smoked pipe. *John Lister, M.D. By the London Post. New England J. Med. Oct.* 28, 1954.



Part of the clinical picture may suggest that you are dealing with a "caffein-sensitive" patient. If that is the case, he can readily change from coffee containing caffein to Sanka Coffee—97% caffein-free.

N.B. Doctor, you'll like Sanka Coffee, too. It is a choice blend with a flavor and aroma that is delightful.



Products of General Foods

SANKA COFFEE

DELICIOUS IN EITHER INSTANT OR REGULAR FORM

Fair, fat, and forty

Griffin and Smith surveyed the records of 245 permanent residents of Rochester, Minn., in whom a diagnosis of gall bladder disease was established at the Mayo Clinic during 1948-49. They concluded that the dictum, "fair, fat, female of 40" as a concept of the typical patient who had disease of the gall bladder be abandoned because it can lead to a serious error. Despite the limitations of the study, which Griffith and Smith pointed out, it was shown that cholecystic disease occurred in all age groups from 15 to 76 or more and that there were as many patients with the disorder between the ages of 26 and 30 as between the ages of 41 and 45. In fact, 3.3 per cent of the patients were 20 years or less, 2.9 per cent were between 21 and 25 years of age, and 8.2 per cent were between 26 and 30. The authors emphasized the frequent occurrence of cholecystitis in adolescents and young adults and pointed out that failure to appreciate this fact led to a number of initial erroneous diagnoses in this series. *David Seegal, M.D. Some Observations on the Beginnings Of Chronic Disease. J. Chron. Dis. Jan.* 1955.

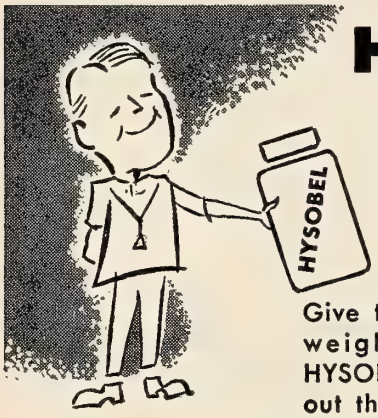
‹‹‹ ›››

The elevated diastolic pressure

Hypertension is suspected in this clinic whenever the diastolic pressure has been recorded as 90 or higher on any occasion, and is defined as the repeated finding of a casual, diastolic pressure of 90 mm. of mercury or more after the exclusion of those with transient rises in blood pressure, those with marked obesity (unless repeated values are in excess of 105), and those with possible arteriosclerotic causes (unless repeated values are in excess of 100). *George A. Perera, M.D. Hypertensive Vascular Disease. J. Chronic Dis. Jan.* 1955.

‹ ›

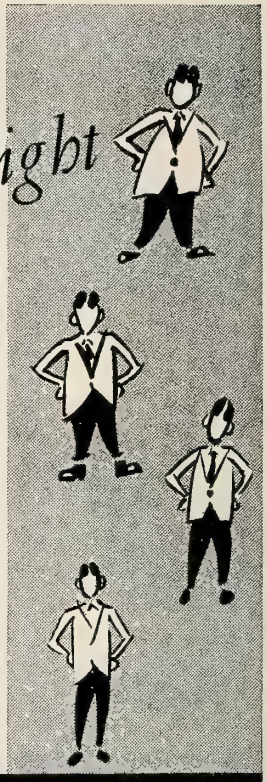
At 20 years of age the will resigns; at 30, the wit; and at 40, the judgment. *Gratian.*



HYSOBEL

for those who want to lose weight

Give them the help they need to lose the weight that endangers their health. HYSOBEL. Convenient tablets with or without thyroid and phenobarbital.



HYSOBEL

d-Desoxyephedrine Hydrochloride	.5 mg.	(1/12 gr.)
Methylcellulose	0.15 Gm.	(2½ gr.)
Thyroid	15 mg.	(¼ gr.)
Phenobarbital	8 mg.	(⅛ gr.)

HYSOBEL NO. 2

d-Desoxyephedrine Hydrochloride	.5 mg.	(1/12 gr.)
Methylcellulose	0.15 Gm.	(2½ gr.)

Supplied in Bottles of 1000, 500 and 100 Tablets

THE ZEMMER CO.

Oakland Station, Pittsburgh 13, Pa.

No matter how you measure it, AUREOMYCIN can claim a distinguished record: in terms of published clinical trials—there are more than 7,000; as for actual doses administered — the figure is more than a *billion*.

But the most significant fact is told by time. For seven years, AUREOMYCIN has been in daily use, repeatedly employed by thousands of physicians throughout the world. Again and again, it has proved to be a reliable broad-spectrum antibiotic; well-tolerated, prompt in action, effective in controlling many kinds of infection.

A CONVENIENT DOSAGE FORM FOR EVERY MEDICAL REQUIREMENT

Seven years great



7

MYCIN*

HYDROCHLORIDE
Chlortetracycline HCl

Lederle

LEDERLE LABORATORIES DIVISION *AMERICAN Cyanamid COMPANY* Pearl River, New York

*TRADE-MARK

Do You Know ? ? ?

THE SPECIAL DISABILITY PLAN

AVAILABLE TO MEMBERS OF

THE ILLINOIS STATE MEDICAL SOCIETY

Provides Benefits up to . .

$5000. ACCIDENTAL DEATH AND DISMEMBERMENT

$100. PER WEEK FOR TOTAL LOSS OF TIME as the result of either Sickness or Accident.
$15. DAILY HOSPITALIZATION for up to 90 days as the result of either Sickness or Accident.

Plus . . .

Optional 5 Year Sickness Coverage
No reduction in benefits because of other insurance
Full benefits to age 70 at same cost
(All Benefits Subject to Provisions of the Policy)

FOR ALL THE FACTS - - -
Write or Telephone

PARKER, ALESHIRE & COMPANY

175 W. JACKSON BOULEVARD
Chicago 4, Ill. **WAbash 2-1011**

Mercy Hospital Institute of Radiation Therapy

The Henry Schmitz Medical Group

For Appointment
VIctory 2-4700, Ext. 170 or RAndolph 6-4444

Herbert E. Schmitz, M.D., *Director*
Peter A. Nelson, M.D., *General Oncology*
Henry L. Schmitz, M.D., *Internal Medicine*
Janet Towne, M.D., *Gynecology*
Robert L. Schmitz, M.D., *General Surgery*
John F. Sheehan, M.D., *Pathologist*
Charles J. Smith, M.D., *Gynecology*
Charles S. Gilbert, M.D., *Internal Medicine*
William F. Cernock, M.D., *Internal Medicine*
Fred W. Eims, *Physicist*
Miss Hilda Waterson, R.N.
Helen Hansen, *Social Service*

COMPLETE TUMOR THERAPY
Including
SUPERFICIAL X-RAY THERAPY
DEEP X-RAY THERAPY up to 1,000 K.V.
RADIUM THERAPY

Daily Consultation at Institute
Tumor Clinic—Mercy Free Dispensary—Tuesday at 9 a. m.
Tumor Conference — J. B. Murphy Auditorium — Friday at 1 p. m.

Treatment of hepatic coma

Treatment of the patient in hepatic coma is discouraging. The usual therapy of chronic liver disease, diet, vitamins, liver extract, and intravenous glucose is necessary. Protein in the diet probably should not exceed two grams per kilogram per day. The value of steroids in therapy of hepatic coma has not been determined. We feel that these drugs are indicated since they seemed to be of some benefit in a few of our patients to whom they were given during the period of confusion before the onset of deep coma. Of greatest importance is the avoidance of compounds containing ammonia or those that will increase the body ammonia such as acetazolamide, cation exchange resins, and amino acid preparations. Paracentesis should be done with extreme caution and with the removal of not more than one or two liters of fluid. Careful attention should be directed to the serum electrolytes. Occasionally it is necessary to administer hypertonic salt solution to correct hypnatremia. Supplemental potassium is practically always necessary. The hemoglobin should be kept as near normal as possible by means of blood transfusions. Antacids and slight elevation of the patient's head are sometimes helpful in preventing bleeding from esophageal varices. Recently Walshe and others have reported successful use of intravenous sodium glutaminate in hepatic coma. If our present concepts as to the pathogenesis of this syndrome are correct, this should be useful in the management of these patients. *Charles Andrews, M.D., et al. Hepatic Coma. J. Kansas M. Soc. March* 1955.

‹ ›

Miniature chest films

The subjective variation in the reading of miniature chest films introduces a considerable error in this diagnostic procedure. There is variation in deciding which films are positive and which are negative. There is even greater variation in the diagnostic impressions obtained from chest films by different readers. Further study is needed to discover methods for minimizing these variations in the art of reading chest films. *William Weiss, M.D. Subjective Variation in Dignostic Impressions Of Miniature Chest Films. J. Philadelphia Gen. Hosp. March* 1954.



Establishing desired eating patterns

Obedrin®

and the 60-10-70 Basic Diet

With Obedrin and the 60-10-70 Basic Diet, the overweight patient receives specific, proved aids to control overeating. Loss of weight is accomplished more comfortably, while the patient develops new and better eating habits.*

OBEDRIN CONTAINS:

Methamphetamine for its anorexigenic and mood-lifting effects.

Pentobarbital as a corrective for any excitation that might occur.

Vitamins B_1 and B_2 plus niacin for diet supplementation.

Ascorbic acid to aid in the mobilization of tissue fluids.

Obedrin contains no artificial bulk, so the hazards of impaction are avoided. The 60-10-70 Basic Diet provides for a balanced food intake, with sufficient protein and roughage.

*Eisfelder, H. W.: Am. Pract. & Dig. Treat., *5*:778 (Oct. 1954).

FORMULA:

Semoxydrine HCl (Methamphetamine HCl) 5 mg.; Pentobarbital 20 mg.; Ascorbic acid 100 mg.; Thiamine HCl 0.5 mg.; Riboflavin 1 mg.; Niacin 5 mg.

Write for 60-10-70 Diet Pads, Weight Charts, and samples of Obedrin.

The S. E. MASSENGILL COMPANY

Bristol, Tennessee

for CHILDREN with EDUCATIONAL and ADJUSTMENT PROBLEMS

. . . a private resident school for children of average or superior intelligence whose psychological difficulties impair their learning abilities and school progress.

. . . enrolling children from seven to fourteen years of age. Coeducational. Small classes. Remedial reading. Brochure on request.

. . . provides a program of education with psychotherapy.

. . . out-patient psychiatric evaluation and consultation for children.

ANN ARBOR SCHOOL

A. H. Kambly M.D., Director

411 First National Building Ann Arbor, Mich.

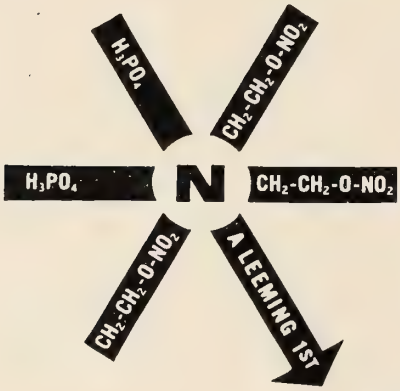
Pyloric obstruction

The existence of pyloric obstruction in individuals with duodenal ulcer is not necessarily a bad omen if the obstruction responds to conservative treatment. A group of 36 patients with duodenal ulcer were observed who had a transitory six hour residue of less than 50 per cent of the barium meal present at the onset of treatment. Symptoms disappeared within three or four weeks under conventional therapy. The subsequent clinical course compared satisfactorily with that of other individuals who had not been obstructed. Persistent pyloric obstructions not yielding to medical management, which includes adequate nightly lavage, usually are followed by unsatisfactory results if medical treatment is continued. *Charles A. Flood, M.D. The Results Of Medical Treatment of Peptic Ulcer. J. Chron. Dis. Jan.* 1955.

‹ ›

As a cure for worrying, work is better than whisky. *Thomas A. Edison.*

Angina pectoris prevention



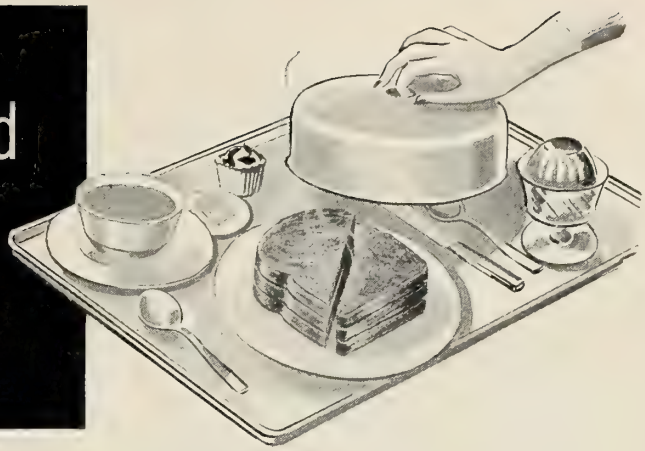
Most efficient of the new long-acting nitrates, METAMINE prevents angina attacks or greatly reduces their number and severity. Tolerance and methemoglobinemia have not been observed with METAMINE, nor have the common nitrate side effects such as headache or gastric irritation. Dose: 1 or 2 tablets after each meal and at bedtime. Also: METAMINE (2 mg.) with BUTABARBITAL (¼ gr.), bottles of 50. THOS. LEEMING & CO., INC., 155 EAST 44TH STREET, NEW YORK 17, N.Y.

unique amino nitrate

Metamine®

triethanolamine trinitrate biphosphate, Leeming, tablets 2 mg. Bottles of 50 and 500

Enriched Bread in Special Diets



THE many advantages of enriched bread in special diets are all too seldom recognized or appreciated. Hence, the physical, physiologic, nutritional, and dietetic values of enriched bread warrant detailed enumeration.

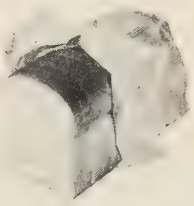
The open, soft texture of enriched bread enables its easy mastication, its ready absorption of digestive juices, and its prompt and thorough digestion. Reflexly, its appetizing eating qualities enhance the digestive processes. Since bread is free from coarse or harsh vegetable fiber, it proves nonirritating mechanically to the gastric and intestinal mucosa. In metabolism its minerals are neutral.

Enriched bread contains less than 0.2 per cent fibrous material, yielding insignificant amounts of indigestible residue. It contains only 3 per cent of fat, negligible amounts of purines, no cholesterol, and does not interfere with the digestive or absorptive processes. It contributes to a desirable texture of the food mass throughout the intestine. The contained nutrients are absorbed gradually.

Nutritionally, enriched bread supplies valuable amounts of biologically valuable protein, 8.5 per cent; easily digestible carbohydrate, essentially starch and dextrins, 52 per cent; and minerals, 1.8 per cent. Enriched bread provides notable amounts of vitamins and minerals: each 100 grams supplies on the average 0.24 mg. of thiamine, 0.15 mg. of riboflavin, 2.2 mg. of niacin, 88 mg. of calcium, 92 mg. of phosphorus, and 2.6 mg. of iron. Also it provides 275 calories of nutrient energy per 100 grams.

Enriched bread, in either fresh or toasted form, contributes to the eating pleasure of many other nutritious foods. Its neutral flavor permits it to blend well with other foods.

For these reasons, enriched bread enjoys a prominent place in a great variety of special diets—soft, low residue, low purine or cholesterol diets, general hospital diets, as well as diets low or high in carbohydrates, in proteins, or in calories.



The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

AMERICAN BAKERS ASSOCIATION
20 NORTH WACKER DRIVE • CHICAGO 6, ILLINOIS

WE CORDIALLY INVITE YOUR INQUIRY for application for membership which affords protection against loss of income from accident and sickness (accidental death, too) as well as benefits for hospital expenses for you and all your dependents.



SINCE 1902

ALL PREMIUMS COME FROM

PHYSICIANS SURGEONS DENTISTS

ALL BENEFITS GO TO

$4,500,000 ASSETS
$22,500,000 PAID FOR BENEFITS

PHYSICIANS CASUALTY AND HEALTH ASSOCIATIONS
OMAHA 2, NEBRASKA

More on tobacco research

If tobacco smoke can be cleared of any blame in the pathogenesis of human ailments, despite impressive statistical evidence that such genetic factors exist, it should so be cleared. Otherwise, the obvious duty of the industry is to find and remove the offending substances if public confidence in the innocuousness of smoking is to be restored. Evidence that the producers are prepared to do just this, if possible, is practically guaranteed by the personal reputations of the nine distinguished scientists who have consented to serve on the Scientific Advisory Board to the Tobacco Industry Research Committee, and by the recent statement of policy that has been adopted by the Board. According to this statement, the Committee not only guarantees to scientists receiving grants the privilege of working with the greatest freedom and without domination of any kind, but also encourages them to exercise this freedom. It furthermore approves the initial presentation of research results in accepted medical and surgical journals and before accepted medical or scientific socities, and the subsequent dissemination to the public of the conclusions reached. The Tobacco Industry Research Committee is to be congratulated on the adoption of such a statement proposed by such a group. So long as these policies prevail, confidence in the scientific integrity of the pending appraisal is justified. *Editorial. Tobacco Road. New England J. Med. March* 24, 1955.

‹ ›

One pound of learning requires ten pounds of common sense to apply it.

— Persian proverb

THUMBSUCKING
since infancy caused this malocclusion.



THUM
TRADE MARK

THUM broke the habit and teeth returned to normal position.

ACCEPTED FOR ADVERTISING IN PUBLICATIONS OF THE AMERICAN MEDICAL ASSOCIATION

Get Thum at your druggist or surgical dealer.
Prescribed by physicians for over 20 years.

Terra-Cortril

brand of oxytetracycline and hydrocortisone

topical ointment



Terra-Cortril Topical Ointment rapidly clears both underlying inflammation and superimposed infection, through the combined actions of CORTRIL®—most potent anti-inflammatory adrenocortical steroid;[1] and TERRAMYCIN®—"perhaps the most effective antibiotic in pyogenic skin diseases."[2]

supplied: In 1/2-oz. tubes containing 3% TERRAMYCIN (oxytetracycline hydrochloride) and 1% CORTRIL (hydrocortisone, free alcohol) in a specially formulated, easily applied ointment base. **also available:** CORTRIL Topical Ointment and CORTRIL Tablets.

1. Rukes, J. M., et al. · Metabolism 3:481, 1954.
2. Peterkin, G. A. G.: Brit. M. J 1:522, 1954.

PFIZER LABORATORIES *Pfizer* Division, Chas. Pfizer & Co., Inc. Brooklyn 6, New York

specify

LEDERLE

POLIOMYELITIS IMMUNE GLOBULIN

(human)

Lederle

For the modification of measles and the prevention or attenuation of infectious hepatitis and poliomyelitis.

LEDERLE LABORATORIES DIVISION

AMERICAN Cyanamid COMPANY Pearl River, New York

No one is perfect

In the admirable effort to examine the child fully from head to foot, few children will come through the examination without some finding that veers from the examiner's conception of the norm. This statement may be accepted as a truism; for if one were to examine any living specimen with more than usual effort, some abnormality would be detected. For example, a flower might have a minor variation in the size or color of the petals; an animal, a slight disparity in the length of the ears. These deviations usually have little effect on the health or life expectancy of the subjects studied. No one has expressed this idea more lucidly than Ralph Waldo Emerson, when he wrote: "There is a crack in everything God has made." *Thomas E. Cone, Jr., M.D. Iatrogenesis Pediatricia. GP Feb.* 1955.

‹ ›

Evidence on all sides shows that the enduring health programs are those the people have understood and those they have had a hand in developing. *Hugh R. Leavell, M.D., Dr. P.H., Amer. J. of Pub. Health, Nov.,* 1954.

today's health

AMERICA'S AUTHENTIC HEALTH MAGAZINE

SPECIAL HALF-PRICE RATES FOR PHYSICIANS, MEDICAL STUDENTS, INTERNS

a good buy in public relations

. . . place
today's health
in your reception room

Give your order to a member of your local Medical Auxiliary or mail it to the Chicago office.

TODAY'S HEALTH
PUBLISHED MONTHLY BY THE
AMERICAN MEDICAL ASSOCIATION
535 NORTH DEARBORN • CHICAGO 10

Please enter ☐, or renew ☐, my subscription for the period checked below:

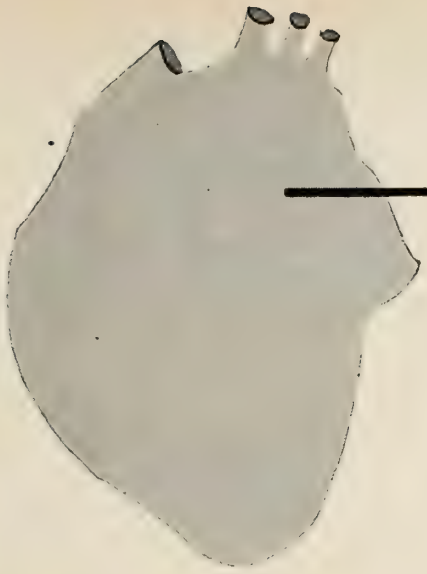
NAME_____

STREET_____

CITY_____ ZONE____ STATE_____

CREDIT WOMAN'S AUXILIARY OF _____ COUNTY

☐ 4 YEARS ... ~~$8.00~~ $4.00 ☐ 2 YEARS ... ~~$5.00~~ $2.50
☐ 3 YEARS ... ~~$6.50~~ $3.25 ☐ 1 YEAR .... ~~$3.00~~ $1.50



NOW! 12 HOUR SUSTAINED CORONARY VASODILATION

with 1 Pentritol Tempule*

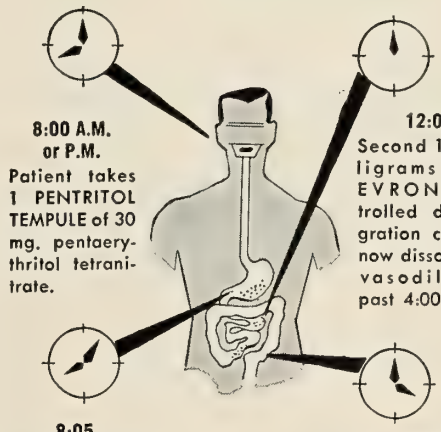
*** CONTROLLED DISINTEGRATION CAPSULE FOR ANGINA PECTORIS**
and other Coronary Insufficiencies.



This new capsule of 30 mg. pentaerythritol tetranitrate is specifically designed to dissolve in three therapeutic releases at 4-hour intervals. Each release affords 4-hour sustained coronary vasodilation. One Pentritol Tempule on arising and one after dinner will control most cases of angina pectoris around the clock. Patient is not endangered by an opportunity to forget medication all day. Patient can sleep through the night with no medication gap. Also available as PENTRITOL-B with 50 mg. butabarbital for 12-hour coronary vasodilation plus sedation.

SAMPLES AND LITERATURE ON REQUEST

Visit our Booth 54 during your Illinois State Medical Society Meeting, May 17-20.



Pentaerythritol Tetranitrate (PETN)

PETN proved one of the best of 14 drugs tested for relief of angina pectoris (1, 2, 3). Pentritol Tempules now extend sustained action through a full 12 hours.

1. Platz, N. Y. State Med. Jl. 52:16 (Aug. 15, 1952)
2. Russek and Assoc., 153:3 J.A.M.A. (Sept. 19, 1953)
3. Winsor and Humphreys, Angiology 3:1 (Feb. 1952)

the Evron company, inc. Chicago 13, Ill.

North Shore Health Resort

on the shores of Lake Michigan
WINNETKA, ILLINOIS
NERVOUS and MENTAL DISORDERS
ALCOHOLISM and DRUG ADDICTION
Modern Methods of Treatment
MODERATE RATES

Established 1901 — *Fully Approved by the*
Licensed by State of Illinois — *American College of Surgeons*

SAMUEL LIEBMAN, M.S., M.D.
Medical Director

225 Sheridan Road — Winnetka 6-0211

DOCTOR! you will approve the
3C's
Comfort, Cleanliness,
Convenience



at Bee Dozier's 3 Sanitariums for
Aged, Chronic, Senile, Convalescent Patients.

Hickory Hill,
Maple Hill, *Palatine*

Charming, healthful rural locations conveniently situated, 24 hour care by trained nurses and orderlies, tempting food and supervised diets all contribute to your patient's well-being or recovery. 18 years of experience.

ONE rate covers EVERYTHING. There are NO extras.

Bee Dozier invites your inspection. Write Box 288, Lake Zurich, Ill., or Phone 4661

Relief for advanced cancer

In an effort to develop a new approach to the definitive palliation of patients with advanced cancer, 100 cases were treated with large doses of ACTH or cortisone, administered simultaneously with nitrogen mustard. The majority of the 100 patients were in advanced or terminal phases of cancer and had failed to respond successfully to previous surgical, radiation, or hormone therapy. Unusual temporary remissions for intervals as long as three years were obtained in 16 per cent of patients, often with associated tumor regression or arrest. An additional 15 per cent received good palliation, with prolongation of life in increased comfort. The remaining 69 patients were classed as fair (29 per cent) or poor (40 per cent) in palliative response and received little or no benefit. *William D. McCarthy, M.D. The Palliation and Remission of Cancer With Combined Corticosteroid and Nitrogen Mustard Therapy. New England J. Med. March* 24, 1955.

FAIRVIEW
Sanitarium

DEVOTED TO THE ACTIVE TREATMENT OF

MENTAL and NERVOUS DISORDERS

Specializing in Psycho-Therapy, and Physiological therapies including:

- Electro-Shock
- Electro-Narcosis
- Insulin Shock
- Carbon Dioxide Therapy

Out Patient Shock Therapy Available

ALCOHOLISM Treated by Comprehensive Medical-Psychiatric Methods.

2828 S. PRAIRIE AVENUE, CHICAGO 16 **J. DENNIS FREUND, M. D., Medical Director**

Phone Victory 2-1650 **Registered by the American Medical Assn.**

The NORBURY SANATORIUM

JACKSONVILLE, ILLINOIS — INCORPORATED and LICENSED

For the Treatment of Nervous and Mental Disorders

FRANK GARM NORBURY, M.D., Medical Director
HENRY A. DOLLEAR, M.D., Superintendent
FRANK B. NORBURY, M.D., Associate Physician

Address Communications — THE NORBURY SANATORIUM, Jacksonville, Illinois

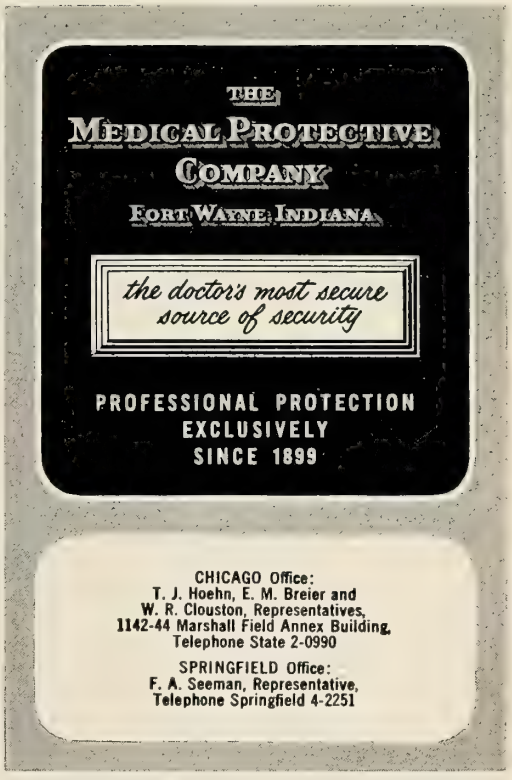
Prevention on penicillin reactions

It appears that with the increasing use of penicillin, more anaphylactic reactions are to be expected. Probably the prevention of such reactions will depend largly upon several factors: (1) Stopping the indiscriminate use of penicillin preparations, especially lozenges, ointments, gargles, tooth pastes, and gums; (2) Protecting patients that are sensitive by giving them cards stating they are sensitive, or by tattooing them; (3) Interrogating patients concerning penicillin sensitivity before using penicillin therapy; and (4) Using a skin test in those persons suspected of being sensitive to penicillin. *L. M. Morrisset, M.D., Penicillin Anaphylaxis. Texas J. Med. Feb.* 1955.

‹ ›

Ain't it the truth?

"Breathes there a man with soul so dead
Who has not cursed that truck ahead?"
Nebraska M.J., Dec. 1954 (*from Redbook, Nov.* 1954).



in whooping cough

ELIXIR BROMAURATE

IS A UNIQUE REMEDY OF UNIQUE MERIT

Cuts short the period of illness and relieves the distressing spasmodic cough. Also valuable in Bronchitis and Bronchial Asthma.

In four-ounce original bottles. A teaspoonful every 3 to 4 hours.

Prescribed by Thousands of Doctors

GOLD PHARMACAL CO. — NEW YORK CITY



Particularly now...

Why is **KENT** the one fundamentally different filter cigarette?

The more brands of filter cigarettes that are introduced—the more innovations in filtering—the clearer becomes the difference in KENT. Consider for a moment why.

Only KENT, of all filter brands, goes to the extra expense to bring smokers the famous Micronite Filter. All others rely solely on cotton, paper or some form of cellulose.

Indeed, the material in KENT's Micronite Filter is the choice in *many* places where filter requirements are most exacting.

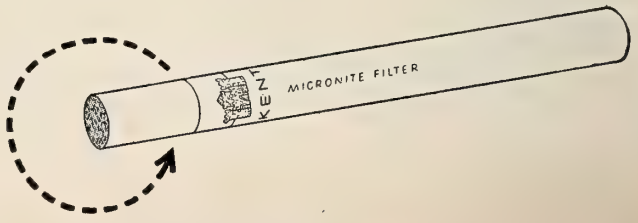
With such filtering efficiency, it is understandable why KENT with the Micronite Filter takes out even microscopic particles —why KENT is *proved* effective in impartial scientific test after test.

Taste will tell the rest of the story.

For KENT's flavor is not only light mild. It stays fresh-tasting, cigarette a cigarette.

May we suggest you evaluate KENT yourself, doctor? We firmly believe th with the first carton, you will reach same conclusion. As always, there i difference in KENT. And now more t ever before.

KENT
with exclusive
MICRONITE
FILTER



"KENT" AND "MICRONITE" ARE REGISTERED TRADEMARKS OF P. LORILLARD CO

Table of Contents

JUNE, 1955
Vol. 107, No. 6

Index to Volume 107 335

ORIGINAL ARTICLES

The Personality of Medical Practice, Arkel M. Vaughn, M.D., Chicago, President, Illinois Medical Society 283

Allergy and The General Practioner, Ethen Allan Brown, M.D., F.A.C.A., and N. John Colombo, M.D., F.A.C.A. (Associate) Boston, Mass. 287

Bacterial Diarrhea, John P. Burgess, M.S., M.D., Rock Island 292

Virus Diarrhea, W. R. Elghammer, M.D., Danville 294

The Rh Problem in Obstetrics, Joseph J. Mullen, M.D., Chicago .. 296

Treatment of Chronic Erythematosus with Atabrine and Chloroquine, Richard B. Stoughton, M.D., Chicago 299

Ocular Manifestations in the Mentally Deficient, L. B. Kamenetz, M.D., Dixon 302

Accommodation and Problems in Ocular Motility, Beulah Cushman, M.D., and Devereaux Jarratt, M.D., Chicago 305

Indications for Mitral Valvulotomy, Robert L. Grissom, M.D., Omaha, Neb. 308

What Lies Ahead in the Field of Nutrition, William J. Darby, M.D., Ph.D., Nashville, Tenn. 311

Cook County Hospital Case Records. One Hundred Consecutive Appendiceal Masses in Children, Frank Milloy, Jr., M.D. and Egbert H. Fell, M.D., Chicago 315

EDITORIALS

Diagnosis of benign gastric ulcer 321

Proposed Maternal Welfare Committee for Illinois 321

Kendall County Medical Society reorganized 322

James C. Leary 323

A.M.A. plans new type health exhibits 324

MEDICAL ECONOMICS

Nursing Scholarship, W. Robert Malony, M.D., Pittsfield 325

CORRESPONDENCE

Clinics for crippled children listed for July 327

Rocky Mountain Cancer Conference 327

NEWS OF THE STATE 329

Editor
Harold M. Camp
Monmouth, Illinois

Associate Editor
Theodore Van Dellen
Chicago, Illinois

Business Manager and Managing Editor
Mr. L. E. Malley
185 N. Wabash Avenue
Chicago 1, Illinois

Business Office
185 N. Wabash Avenue
Chicago 1, Illinois

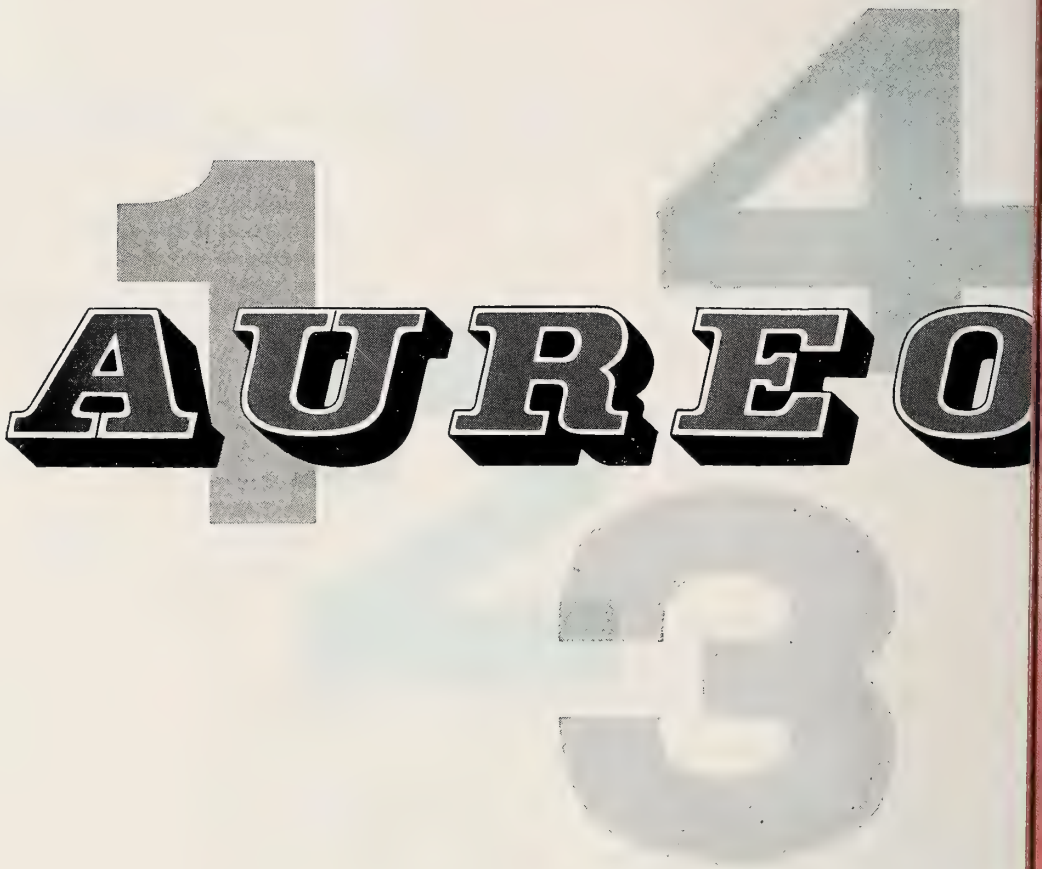
Editorial Office
Medical Arts Building
Monmouth, Illinois

Send original articles and membership correspondence to Harold M. Camp, Monmouth, Ill.

Send changes in the mailing list to Managing Editor, 185 N. Wabash Ave., Chicago 1, Ill.

Subscription price of this JOURNAL to persons not members of the Illinois State Medical Society is $4.00 per year, in advance, postage prepaid, for the United States, Cuba, Puerto Rico, Philippine Islands, Hawaiian Islands and Mexico. $5.00 per year for all foreign countries included in the postal union. Canada, $4.50. Single current copies 50 cents. By mail, 60 cents.

Entered as Second-Class Matter November 12, 1952 at the Post Office, Mendota, Illinois, under the Act of March 8, 1879. Acceptance for mailing at special rate postage provided for in section 1102, Act of October 8, 1917, authorized July 15, 1918. Printed monthly by The Wayside Press, Mendota, Illinois. Office of Publication, 1501 W. Washington Road, Mendota, Illinois. POSTMASTER — Return undeliverable copies under form 3579 to 1501 W. Washington Road, Mendota, Illinois.


AUREO

protection for pregnant and lactating patients

NATABEC®
KAPSEALS®

vitamin-mineral combination

When nutritional demands are highest, NATABEC Kapseals help protect your patients with important vitamins, the intrinsic factor, plus iron and calcium. Optimum nutrition safeguards present and future health of both mother and child.

DOSAGE: As a dietary supplement during pregnancy and lactation, one or more Kapseals daily as directed by the physician. Available in bottles of 100 and 1,000.



PARKE, DAVIS & COMPANY
DETROIT, MICHIGAN

MEDICAMENTA VERA

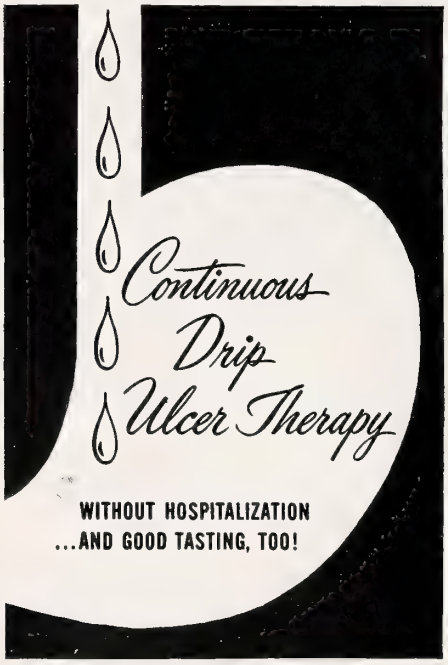
The changing physician-hospital relationship

The governing and administration of hospitals have undergone radical change, for which the profession has been in large part responsible. The American College of Surgeons, in its efforts to raise the standards of hospitals, recommended that physicians be eliminated from the governing boards of hospitals. This step was not without reason but unfortunately it has not been an unmixed blessing. The importance of the doctor remains but his influence in the operation of hospitals is becoming less and less. He is rapidly asuming the status of an employee, a sort of technician who accepts the shortcomings and inefficiency of hospital operation as an evil against which he is powerless. Authority and responsibility go together and if lay boards and directors assume authority, they likewise assume responsibility for medical care. Deficiencies in hospital administration would not be of such importance if they were not reflected in the rising cost of medical care and public dissatisfaction. Efficiency of operation cannot be attained without the wholehearted co-operation of the medical staff, which is unlikely to be achieved without greater participation and responsibility in administrative matters. *A. W. Oughterson, M.D. SURGERY, SCIENCE, AND SOCIETY. New England J. Med. March* 24, 1955.

‹ · ›

"Sex sense"

There is no reliable or practical method of determining fetal sex, despite the many "sex tests" developed past and present. Although there is little doubt that some day there will be a method that will enable us to give Mrs. Brown hysterics by telling her she will have her tenth girl, it is best to be slow to accept any sweeping claims for a 100 per cent accurate test for, at present, most belong in the realm of flying saucers and cracked windshields. *C. A. Stern, M.D. Will It Be A Boy Or Girl? South Dakota J. Med. & Pharm. March* 1955.



HORLICKS CORPORATION
Pharmaceutical Division
RACINE, WISCONSIN

Nulacin

A recent clinical study* of 46 ambulatory nonhospital patients treated with Nulacin† and followed up to 15 months describes the value of ambulatory continuous drip therapy by this method. Total relief of symptoms was afforded to 44 of 46 patients with duodenal ulcer, gastric ulcer and hypertrophic gastritis.

The delicately flavored tablets dissolve slowly in the mouth (not to be chewed or swallowed). They are not noticeable and do not interfere with speech.

Nulacin tablets are supplied in tubes of 25 at all pharmacies. Physicians are invited to send for reprints and clinical sample.

*Steigmann, F., and Goldberg, E.: Ambulatory Continuous Drip Method in the Treatment of Peptic Ulcer, Am. J. Digest. Dis. *22*:67 (Mar.) 1955.

†Mg trisilicate 3.5 gr.; Ca carbonate 2.0 gr.; Mg oxide 2.0 gr.; Mg carbonate 0.5 gr.

The
ILLINOIS
Medical Journal

Official Journal of The Illinois State Medical Society

JUNE 1955
VOL. 107 NO. 6

The Personality of Medical Practice

ARKELL M. VAUGHN, M.D., CHICAGO, President, Illinois State Medical Society

TWO years have elapsed since you accorded me the privilege of serving the Illinois State Medical Society and the medical profession, in a high position of trust. I have already given the House of Delegates an accounting of my tenure as president; now I have the opportunity to discuss before this general assemblage some of my personal feelings about the practice of medicine.

In recent years there has developed a trend among individuals and groups outside the medical profession to try to dominate the physician's conduct of his practice. It has manifested itself in many ways and through many persons. As a profession, we seem to attract kibitzers like a honey tree draws bears. This situation would be of little consequence except that it poses a very serious threat to the doctor-patient relationship, which we all agree should be inviolable.

When a person has gone to the trouble of selecting a doctor for himself and his family, he should never be deprived of the physician's services and consultation, no matter what the circumstances. The relationship between a doctor and his patient is an individual matter of an intimate nature. It involves the establishment, over a long period of time, of mutual confidence and trust. The mandatory injection of a third party in this relationship can lead only to confusion and a lower quality of medical service.

I am very proud of the strong position the Illinois State Medical Society has always maintained against encroachments of our professional prerogative. It takes courage to hold to a principal when the pressures are great in the opposite direction.

Our difficulties have often resulted from failure to adequately inform the public of the reasons for our various actions. I have seen occasions when we were forced into a defensive position because we didn't take the time to conduct an educational program. As members of the state society we all know the problems which confront us, but no amount of talking amongst ourselves can substitute for an occasional appearance before a non-professional group. We have a GOOD story to tell, and we should tell it at every opportunity — before the chambers of commerce, the Lions Clubs, the Rotarians, the Women's federations, the veterans groups, the church lay organizations and the many other audiences which are available.

How many people, do you suppose, know of the spectacular progress that the citizens of our country have made in voluntarily protecting themselves against the cost of sickness? And

how many of them know of the important role that state and county medical societies, including our own, played in creating and encouraging these health insurance programs?

We have every reason to be proud of the fact that more than 100,000,000 Americans are now protected against the cost of hospital expense on a voluntary basis. Over 82,000,000 of our citizens are covered for surgical expense and more than 43,000,000 carry medical expense insurance. In addition, there are now nearly 1,500,000 persons carrying the major medical expense insurance for protection against the cost of long-term illness, which sometimes amounts to thousands of dollars. This type of coverage is a relative newcomer in the field of health insurance and the number of policyholders will undoubtedly increase greatly. As a matter of fact, the Blue Cross-Blue Shield Commissions, at their recent annual meeting in Chicago decided to go ahead with plans for writing such contracts at a nominal additional cost to those of their present policyholders who wish to take advantage of the offer. The number of large commercial insurance firms in this field is steadily increasing.

The impressive gains in voluntary health insurance coverage during the past few years have provided an adequate rebuttal to those who foster socialism. America's citizens have proved beyond a doubt their ability and desire to take care of themselves. Latest available studies show that 85 per cent of American families are free of medical debt. Of the remainder, only about two per cent owe $195 or more.

Illinois physicians, like doctors throughout the rest of the nation, give many hours of their time each week in caring for the medically indigent — persons who cannot afford to pay for their medical care. If the value of such services were to be tabulated each year, it would add up to millions of dollars.

As physicians we can only provide our services without charge to the indigent. The matter of hospitalization for these individuals is the responsibility of the local taxpayers, as it has been historically.

We have a great medical center in Chicago, perhaps the finest in the world. Our teaching and research facilities are superb, and we in this state have contributed much to the advancement of medical science.

In reading the "History of Medical Practice in Illinois from 1850-1900," recently published, and a book which every physician should read, it is noted that this state has given many famous physicians and surgeons to the world in the past century. To name a few:

Dr. N. S. Davis, who organized (1) The American Medical Association, (2) The Illinois State Medical Society, and (3) The Chicago Medical Society.

William B. Herrick; W. H. Byford; J. H. Hollister; Frank Billings; Albert J. Ochsner; Bertram W. Sippy; Daniel Brainard; Moses Gunn; Edmund Andrews and son, E. Willis Andrews; D. W. Graham; Joseph De Lee; Christian Fenger; Nicholas Seen; John B. Murphy; E. P. Sloah of Bloomington, L. C. Taylor, of Springfield, David Prince, Frank P. Norbury, and Carl Black all of Jacksonville; W. F. Grinstead of Cairo, Andy Hall, still living and practicing at the age of 91; and numerous others equally famous. The fame of these men was international. Illinois has continued to give other medical world leaders up to the present time. Chicago has the signal honor, I believe, of being the only medical center in the world where 3 pairs of Siamese Twins have been separated. Namely Research and Educational Hospital of the University of Illinois in 1952, Billings Hospital of the University of Chicago and Mercy Hospital of the Stritch School of Medicine of Loyola University in this year, 1955. Patients are brought to our hospitals from every part of the nation and from all over the world.

As a result of the medical progress made in the last two decades, the average length of illness and hospital stay has been reduced markedly. In 1934, the average hospital stay for a patient was about 14½ days; now the figure is just a fraction over nine days. This means that a workingman can get back to his income-producing job much sooner than he would have 20 years ago. This means also a savings in physician's fees and hospital costs.

These are just a few of the things we have to talk about when we speak to groups outside the medical profession. There are many more subjects of equal interest which reflects favorably on the medical profession.

One misconception we can help to straighten out, for example, is the role of the general practitioner in the field of medicine. Although many people profess a yearning for the "old time family doctor," some of them ignore the opportunity to avail themselves of such service by seeking, without prior consultation, the office of a specialist. People should realize that general practitioners can handle the majority of all known ailments; and that a specialist should ordinarily be sought only on the recommendation of the general practitioner.

Specialists are essential in the practice of medicine. There is no question of that. The complexities of modern medical science and the rapid advances which have been made in the past 25 years, make specialists indispensable. No one man can be expected to absorb all of the medical knowledge and the techniques which we have today. However, too much specialization can stultify the practice of medicine and lead to confusion in the public mind. I am encouraged by the fact that there seems to be a growing tendency among medical students to go into general practice — at least for a few years.

The young doctor who engages in general practice before deciding on a specialty, in addition to performing a vital service in a community, also stands a better chance of settling on the work he really likes to do.

The general practitioner should be, in the good tradition of his predecessors, a family counsellor, ranking next to the clergy in the respect and opinion of his patients. The specialists, on the other hand, should learn to regard him as a coordinator or general manager. Too often patients are referred to one specialist after another with no connecting link of reports between them. If the family doctor could, as a matter of regular procedure, obtain the reports of the various specialists his patient may be required to go to, he would then be able to perform an important service of evaluation not only to his patient but to the colleagues to whom he had made the referrals.

There is no substitute for the personalized service that a family doctor can give to the people who place their confidence in him. He gets to know their mental foibles as well as their physical ailments, and he will often be able to discern the real from the imaginary illness.

While it is true that the public relations of the medical profession begins in every doctor's office, the general practitioner has a better opportunity to represent our calling in the best possible light than does the specialist. He has, perhaps, a little more time to spend with them; he sees them under more favorable conditions, in his office or in their homes, for the most part, and gets to talk to them more frequently.

Personally, I think one of the best aids to good public relations is for a doctor to become a patient himself, particularly a surgical patient. I know that my regard for the feelings of my patients increased considerably after I had to undergo an operation and spend some time in a hospital bed.

Good public relations is something you can't buy. You must earn it through diligent observance of the Golden Rule. Your personal public relations begins the moment you say "good morning" or "good afternoon" to your patient. It is expressed in the way you take his history, the way you speak of his complaint, the way you handle his appointment and the way you help him settle his bill. The man who crowds his appointment schedule, who can't find the time to discuss in detail a laboratory report, or who tells his patient that "my secretary handles all matters pertaining to my fee," is doing a disservice not only to his patient but to himself and the profession.

Most of the complaints against doctors originate as a result of misunderstanding. Physicians should take time to explain the various costs of drugs and hospital services, the procedures they intend to follow in medical management or surgery and the fees to be charged for services rendered. The letters of complaint received at state headquarters deal with these subjects for the most part.

In the event grievance committee procedures are required, the county societies must do their best to hear complaints impartially and quickly. The cause of medical public relations is not served when a county society stalls in its handling of a complaint, or renders a decision so ambiguous as to make the entire procedure a farce. If a man is found guilty of wrongdoing, he should be dealt with promptly. The physician

who repeatedly flaunts the Principles of Medical Ethics is no credit to anyone, no matter what the size of his practice or influence in the community.

We have the opportunity to practice medicine but once on this earth. We should do so with the realization that our gift of healing was granted us by a Supreme Being, who created man in His own image and provided him with the faculties to carry on. There is more to the practice of medicine than that which we learn in our medical schools, in the laboratories and the operating rooms. A doctor can only apply the skill which he has acquired. He must rely in every instance on the Almighty God for the ultimate result.

My year as president of this society is now ended. It has been a very eventful time, and I appreciate having had the opportunity to serve you in this way. I don't know how I would have done the job without the splendid cooperation which I received from the officers and council, and the support of the membership. My gratitude to the hard-working members of the headquarters staff is unbounded. I found the nonmedical personnel as dedicated to the advancement of our profession as any physician I have ever met. Jim Leary was an excellent example of the type of person we have working for us. His devotion to duty was great and I felt a deep personal loss at his untimely death.

I know that the Illinois State Medical Society will go ahead with an even better program during the coming year and I want to extend my sincerest best wishes to my successor Dr. F. Garm Norberry. Although my assignment is finished, my heart is still with you.

7918 S. Paxton Ave.

‹ ‹ ‹ › › ›

Tube feeding

The material to be introduced into the stomach (via a tube) should be nonirritating, free of harmful bacteria or their toxins, and should provide calories and the essential vitamins and minerals in adequate amounts. Types of food which can be fed by nasogastric tube are obtainable in most household kitchens, and formulas of their composition and directions for their making are available in the various diet manuals. In addition, there are some preparations on the market that can be used instead of ordinary food materials. Some of them, such as Sustagen, do not require special mixing apparatus, can be prepared simply and conveniently, and cost less than tube feedings made from ordinary foods. This preparation in particular is designed to have a low viscosity in order to pass through small (2 mm.) plastic tubes without clogging, and contains adequate amounts of essential vitamins and minerals. Approximately 890 grams of the powder dissolved in 2,000 ml. of water results in a volume of 2,400 ml. and supplies 3,500 calories in the form of protein (210 Gm.), fat (30 Gm.) and carbohydrate (600 Gm.) *Thomas E. Machella, M.D. Tube Feeding. Pennsylvania M.J. April* 1955.

Allergy and The General Practitioner

Ethan Allan Brown, M.D., F.A.C.A. and N. John Colombo, M.D., F.A.C.A. (Associate), Boston, Mass.

IT HAS frequently been noted that the incidence of certain disorders as uncovered in any one community is a reliable index of the quality of medicine there practiced. This is true, for instance, for cancer, and in our opinion for allergy, if only because present-day allergy pervades almost every aspect of the prophylaxis and treatment of a host of disorders, including those requiring both surgery and a knowledge of the Sub-specialties. As soon as the alerted physician recognizes allergic patients for what they are, and has experienced the successful treatment of their often otherwise puzzling syndromes, he begins to take note of some of the other unsuspected, and therefore undiagnosed, untreated, and occasionally mistreated patients who require anti-allergic management.

Few physicians, however well trained, are aware of the large number of disorders which may be mediated by allergic mechanisms. And just as, in the past, they have successively had their indices of suspicion raised for, let us say, Lues, Diabetes, Tuberculosis and Cancer, they should, by now, have become equally allergy-conscious, especially for certain aspects of the subject.

In what portions of the physician's practice will a knowledge of allergy, or the advice or assistance of an Internist-Allergist be helpful? In recent years the outlines of the subject have become well delineated, and the syndromes associated with allergic sensitivity are therefore no longer difficult to define. We now recognize at least seven groups of allergic disorders. These may, in a certain sense, overlap. Previous classifications have occasionally listed the allergic syndromes, sometimes according to morphological characteristics, as in urticaria; historically, according to etiology, as in pollinosis, or else basically, in terms of the organ involved, as in Allergic Tracheitis. The groups are therefore by no means mutually exclusive, as, for instance, when an asthmatic patient who fits into one category, namely atopy, is also sensitive to Penicillin, and therefore may be drug sensitive. In each group, however, the patient often typically presents the characteristics of each syndrome as though it alone were present.

At the onset, let it be stated (if only because knowledge of the basic mechanisms causing allergy is increasing so rapidly) that there is no completely satisfactory definition of either the allergic state or of the allergic reaction. The terms used by immunologists may be too abstract for ordinary needs. Common sense and often over-simplified definitions may omit references to complex and (sometimes hypothetical) immunological interrelationships. All definitions attempt to convey that the allergic subject reacts abnormally, but with a specific and reproducible type of response, to substances which cause no such reactions in, at the moment, non-allergic individuals. The Allergist is, in a manner of speaking, a specialist in the ordinary, in that everyday substances to which almost all of our population may be exposed, frequently cause discomfort, harm, and perhaps death, to his patients.

It might be interesting to speculate as to why allergy, having been recognized for over 3000 years, had to wait so long to become a solid part of the structure of the Medical Sciences. For this there are at least three reasons, all of which continue to affect physicians who are not completely orientated in the subject. It might be noted, as well, that these same reasons distort the thinking of many patients, especially those who have only recently demonstrated allergic disorders.

First, it is difficult for the human mind to accept the fact that (allowing for toxins which may be poisonous to all human beings in variable degree) there might exist a group of varied

substances, ranging from foods and inhalants, as danders, pollens, particulate chemicals, molds, smuts, contactants and drugs, which could, in extremely minute amounts, cause the wide-reaching reactions seen. For instance, how do ten pollen grains in a cubic yard of air conceivably cause status asthmaticus affecting the 30 square yards of pulmonary mucous membrane in a patient weighing, say 200 pounds? Some allergic responses must actually be experienced to be believed. The credulity of many physicians is stretched to the breaking point when they are told that a patient can be proven experimentally and in the laboratory, to respond with thrombocytopenic purpura, to a millionth of a gram of Sedormid.

The second mental hurdle, both the non-allergic and the non-Allergist physicians, and, as well, the allergic patient must all three surmount, is the factor, not only of the effects of minute amounts of ordinary substances, but of the element of times as well. All three wonder why a patient becomes allergic when he does. It appears almost reasonable that an infant might react allergically to cow's milk or orange juice, perhaps because it seems that the response is akin to toxicity, especially when it occurs immediately after the new food is added to the diet. But what of the patients whose first hay fever occurs in late adult life? Such patients almost always wonder why the allergy presented itself when it did, especially when the exposure had been present, let us say, to ragweed pollen, for several decades. The allergist himself has no comprehensive answer to this question, which is often propounded at the very first consultation.

The third obstacle to clear thinking in the field of Allergy has been due to the fact that so many of the manifestations of allergy, especially spasm, could be reproduced by non-allergenic causes. We seem willing to accept 50 reasons for headaches, and perhaps 60 for hemoptysis, but we somehow balk at 10 reasons for bronchospasm. When, for example, the wheezing is caused by sensitivity to animal danders or pollen, the patient's lungs may, as well, be triggered by sensitivity to house dust. He may then respond with an asthmatic attack to intercurrent infection, emotion, exertion, alcoholic ingestion, overeating, exposure to cold air or change of barometric pressure, and reflexly by conditioning to a number of non-specific factors. This has led some physicians and lay workers to reverse cause and effect, and to label all allergic patients — politely as psychosomatic, sometimes more bluntly as neurotic, or, worse still, more crudely as psychotic. Fortunately for us, our practice includes more than 200 physicians and their families, whose symptoms we have seen develop, and in whom the responses are, for want of a better term, labelled as "allergically allergic." From them there are no glib phrases like "Maternal Rejection" and "Oedipus Complex." The allergic child or adult may know that he is causing his parents or relatives much loss of time, money and energy, and therefore he may feel as though he might be rejected. It must, indeed, be rare for him, because he feels rejected, to develop thereafter an urticarial reaction to Penicillin or to Aspirin. That these typical, proven allergic symptoms may be worse in the presence of psychoneurosis, no one will deny. But that they may be the primary cause goes against all clinical and laboratory proof.

Granted that the substances inducing allergic reactions are ordinarily minute in amount and usually harmless, and that the resulting responses are specific and reproducible, we can classify the known allergic syndromes into a number of constellations of signs and symptoms.

The first, "Anaphylaxis," needs no long description. The gap between anaphylaxis and atopy is rapidly being bridged. Atopy is now known to occur naturally in animals, and anaphylaxis may be acquired by humans. The basic facts to recall are that, classically, the sensitivity is artificially induced, usually by exposure to proteins, and that, after a variable incubation period, a second exposure causes either a typical organ or general response, depending on the animal or the patient. If death does not occur, there is frequently a refractory period during which the subject cannot be shocked. If subliminal *injections* are given, the incubation period can be prolonged, and the onset of sensitivity can be delayed, or, after sensitivity has become established, the animal or the patient can be, as it were, made not more, but less sensitive, so that it may be difficult, or impossible, to shock him. Briefly, then, an animal can be sensitized. If its sensitivity is not challenged, it lives out its normal span of life in the sensitized state. If

challenged, it may be shocked and die, or it may be shocked and live. If it lives, it may temporarily be refractory to further shocking.

Quite obviously, the procedures needed to sensitize or desensitize, shocking to kill or shocking to cause refractoriness, differ only as to the techniques used, as based on dose and time. Some such hypothesis may explain, in part, the processes which lead to hyposensitization in some types of human allergy. There are, however, many gaps in our knowledge. The best example of anaphylactoid reactions in humans is undoubtedly serum disease.

The second group of allergic phenomena are those frequently labelled "Atopic." These are usually the allergist's chief concern. By definition are included all typical hay fever patients, a good number of our asthmatic subjects, many eczematous children, and some of the patients suffering from migranoid disorders and urticaria. The atopic process has been proven, and beyond any doubt whatsoever, as the causal mechanism, not only involved in disorders affecting the skin, mucous membranes and smooth muscle organs, but also as the cause of a number of less common reactions in tissues, such as the meninges, the central nervous, cardiovascular, and reticuloendothelial systems, the blood itself, the bone marrow, the gastrointestinal and genitourinary tracts, the joints, and individual organs, such as the eyes, ears, nose, throat, lungs, liver and kidneys.

The typical atopic patient has a strong familial history of allergy, and consistently, over a period of time, often demonstrates more than one manifestation of the allergic response. No matter what the shock organ may be, the symptoms are usually explicable on the basis of increased capillary permeability and mucous membrane edema, or smooth muscle spasm. In many patients the secretions and the blood both present an eosinophilia. In some disorders the tissues often carry what are termed reagins, or passive transfer antibodies, responsible for the positive scratch, pressure puncture and intradermal tests, which help corroborate the history and, in untreated patients, measure with some certainty the degree of sensitivity.

Immunologically, it can be stated that when the sensitized tissue of the patient with an "atopic constitution" meets with a sufficient quantity of the atopen in units of time, the allergic disorder becomes manifest. Sometimes such reactions may be subclinical, and therefore measurable only with instruments, as in the diminished Vital Capacity, both total and by the three second expiration test, seen both in asthmatic patients and often in untreated hay fever patients who have not obviously, as yet, suffered from bronchospasm.

The literature lists approximately 2000 known allergens which, by inhalation, ingestion, injection, or direct contact, will cause this type of response. Fortunately for general practitioners and allergists, fewer than 50 (counting all pollens and all molds as single causes) are responsible for over 90% of our patients' difficulties.

The first pathological processes are almost always completely reversible. In time, permanent tissue changes occur, in which case the discovery of the responsible allergen may do little good. Early diagnosis at the level of the general practitioner may save an asthmatic patient from becoming a "pulmonary cripple." We see many middle-aged patients who have developed fibrotic lung tissue changes and who now suffer from so-called asthmatic bronchitis, with emphysema and cor pulmonale. The most meticulous diminution in exposure to house dust will not help, although tests with moderate measured quantities may cause severe exacerbations. In the present state of our knowledge, such patients might have been able to live normal, useful lives.

At this point, it would be well to discuss the problem of tests, especially when using the skin, conjunctivae, and nasal and pulmonary mucosae. The days of the wooden box holding odd rows of dusty vials with broken corks, handled by a bored technician for poor scratch tests on indiscriminately chosen patients, are long past. Modern skin testing is a very dependable scientific process, as well as a fine art.

Tests can only be as good as the solutions used and the skill and the knowledge of the testing physician. The sensitivity may lie in the category of the disorders in which there are no positive skin tests, as in those in which mechanisms concerned with globulin changes are not present. Negative skin tests may also occur when the skin is refractory, the sensitivity mild, or the solution weak. Skin tests are useful only in certain types and degrees of food allergy. The prepara-

tion of allergenic extracts and their application and interpretation are highly technical procedures. The modern allergist is not a "skin tester", although he may be interested in skin tests.

The next group of allergic disorders is easily described, as well as readily recognized, and yet may nevertheless present the general practitioner, the dermatologist and the allergist with their most complex diagnostic problems. In contact dermatitis, the tissues of the skin demonstrate an epidermal spongiosis. Atopic individuals are no more subject to contact dermatitis than are those who do not suffer from hay fever or asthma. There is no familial allergy, and excepting for a limited number of special contactants, there are no reagins, antibodies or precipitins. A knowledge of the types of contactants to which a patient may be exposed at home or at work, the history of such exposure, the distribution and type of the lesion, will all help the physician or the consultant decide which substances to apply after the acute stage is over, when such patch tests can be done with safety.

It should be noted that clinically some patients react with the first exposure, and some after a variable period of time. Some react immediately, and subsequently become, as it were, hardened. Others react more and more quickly, with more and more severe exacerbations, to less and less contact.

The known and growing list of industrial contactants is available, as arranged alphabetically and by occupational exposure. There are approximately 2500, including 150 plants and almost 90 medicinal products. Here, too, testing calls for background and skill. The dilution used must not cause a positive reaction on normal skin exposed to the same contactant for the same exposure period. Inadequate exposure to a solution too weak to elicit a response does not tell us the basic reason for the dermatitis. Too great a concentration may result in a generalized exacerbation, and, if repeated, may itself bring on additional sensitivity. With proper study, such patients readily respond to treatment and remain well.

The next category of allergic patients includes those sensitive to drugs. They represent an important and growing part of the practice of both general medicine and of allergy. In a recent review of the subject, we were able to present an abbreviated list of approximately 225 drugs known to cause allergic and other reactions. For convenience of reference we listed all sulfonamides, local anesthetics, antihistaminic agents, arsenicals, mercurials, barbiturates, and, as well, excipients, under a single heading. The true number, therefore, is closer to nine hundred. The subject is too vast and too complex to compress into a paper of this type. A reprint, listing the drugs and their known reactions, is available on request.

It must be remembered that in drug allergy the reaction is not due to overdosage, or to cumulative effects. It is not an exaggerated pharmacological response. It differs, therefore, from the toxic effects, and is frequently caused by doses far below normal posological levels. Proof of ingestion, injection, inhalation, instillation or contact may sometimes be difficult to elicit. Diagnostic tests are notoriously undependable. Clinical tests fay be incredibly dangerous. Reactions to drugs may mimic every conceivable medical syndrome, and today should be suspected and ruled out in almost every patient under treatment, certainly before initiating either expensive or extensive etiological investigations.

The fifth group of allergic patients is represented by those sensitive to infectious agents such as bacteria, viruses, fungi or parasites, usually to the proteins, the endotoxins, exotoxins, and occasionally to microbial metabolities. In this group belong those presenting allergic reactions as seen in the exanthemata and enanthemata, the viral reactions of Variola and Lymphogranuloma Inguinale, as well as the reactions seen in tuberculosis and syphilis. These patients need rarely, if ever, be treated for the allergic component of the concommitant disorder, but rather for the original disease, of which the allergic response is only a minor part.

For purposes of record, the list of disorders in which skin tests of the tuberculin type may be diagnostic of either sensitivity or resistance, is as follows; although some are rarely used, since other diagnostic criteria are so often available.

Arranged alphabetically the most important are: actinomycosis, aspergillosis, blastomycosis, cestode infestations, chancroid, coccidioidal granuloma, diphtheria, bacillary dysentery, filariasis, glanders, gonococcal infection, leishmani-

asis, meningococcal meningitis, pneumonia schistosomiasis, hemolytic streptococcal infections, trichinosis, tularemia, typhus fever, and undulant fever.

The sixth category of allergic responses are those described as "foreign protein reactions." Although they truly represent a subdivision of drug allergy, they deserve special emphasis.

By definition, the term "foreign" means only foreign to the blood stream. Some of these substances, often heterologous, may also be biologically derived materials of homologous species, as, for instance, the proteins of the pituitary, thyroid adrenals, the pancreas, and the gonads. In the present Mass Anterior Poliomyelitis vaccine experiment, the serum is derived from monkey kidney tissue. More often, equine and bovine sera are used. The reaction may be immediate, as urticaria, or delayed, as in serum sickness. It may be local, systemic or general in type. It may be associated with fever, joint pains, lymphadenopathy, leukopenia, and various types of eruptions. The diagnosis is not usually difficult, since there is an invariable history of the administration of the foreign protein.

The final group of patients are those who respond abnormally to physical agents, such as heat, cold, light, and mechanical irritation or mild trauma, sometimes with a general dermatitis or a rash, but usually with urticaria or angioneurotic edema. The history is usually easily elicited and the diagnosis not difficult to make or prove. Such physical factors, may, however, affect exacerbations of other forms of allergy as with ultraviolet radiation and sulfonamide sensitivity, or cold air in atopic asthma. In such cases, physical agents act as secondary causes and, in the absence of allergy, may, in themselves, result in little difficulty.

Given an understanding of the fields of allergy the general practitioner can learn to recognize those disorders which are most often allergic; those which are rarely allergic; and those which are not usually due to allergic sensitivity. With these categories in mind, he can take a more complete history, and quickly set the patient on the path toward recovery. When the causes of such responses are known, the treatment is usually not complex. It is much more often simple, and very often dramatically successful.

75 Bay State Road
Boston 15, Massachusetts

39 Church Street
Hudson, Massachusetts

‹‹‹ ›››

Advise safety belts

The writer also has seen, during four seasons in attendance at stock car auto races, over 100 cars roll side over side and end over end, with only one serious injury, and that when a safety belt, required for such stock car drivers, gave way. Although the seat belt is not the only protective device for stock car drivers, it is at once the most important as well as the most easily installed in ordinary autos. This one device usually will prevent the bodies of the occupant from being thrown out of a car which is abruptly stopped or rolled over in a collision. It will slow to a safe degree the deceleration of the human body, which without such protection may decelerate from 88 feet per second to zero upon contact with the inflexible windshield or car frame. The belt is reasonable in cost and can be used inconspicuously and with little inconvenience. *Joseph J. Toye, M.D. A Plea for Safety Belts in Passenger Automobiles. Bull. Suffolk Co. Med. Soc. Sept.* 1954.

Bacterial Diarrhea

John P. Burgess, M.S., M.D., Rock Island

A SYMPOSIUM on chronic diarrhea probably should contain some comments on bacterial diarrhea, yet the enormous literature which has accumulated on the bacteriology of infectious diarrhea does not offer much information regarding the incidence of chronic diarrhea of bacterial etiology. The Bureau of Epidemiology of The Illinois Department of Public Health does not classify reported cases of infectious diarrhea as to their chronicity[1], so that one would have to sift through the case histories of all the reported cases in order to obtain some statistics regarding the incidence of cases that could be termed chronic. Any statistics thus obtained would certainly be unreliable since it is probable that the majority of cases of bacterial etiology might be due to agents not requiring a report. Furthermore, diarrhea is not a disease, but a symptom which does not exist as a bacteriological entity except in those cases recognized as some type of Shigella or Salmonella infection.

Infectious diarrhea is a clinical term which from the bacteriological point of view can be divided into three major classes: (1) diarrhea of known etiology, (2) diarrhea of doubtful etiology, and (3) diarrhea of unknown etiology[2]. The first class comprises the known enteric pathogens of the Salmonella and Shigella groups, and the enterotoxigenic staphylococci, the metabolic products of which are responsible for certain types of food poisoning with vomiting and diarrhea. The second class comprises a large heterogeneous group of bacteria which have at various times been incriminated as the etiologic agent in certain epidemics of diarrhea. These include certain strains of coliform bacilli, certain strains of paracolon bacilli, certain strains of Proteus bacilli, Klebsiella pneumoniae, Pseudomonas aeruginosa, Alcaligenes faecalis, certain Staphylococci, and certain Streptococci. The third class probably encompasses by far the greatest percentage of cases of diarrhea in the temperate climates in which no known etiologic bacterial agent has been established. Suspected agents range from viruses and bacteria to fungi and Protozoa. This class probably also encompasses the parenteral infections which in many reported series show a sizable relationship of gastro-intestinal symptoms.[3] The relationship of parenteral infections to gastroenteritis is certainly indefinite, and it may be that those cases of diarrhea exhibiting respiratory symptoms have a single etiologic agent producing the whole complex which is frequently labeled 'intestinal flu' by the laity.

It is a well established fact that bacillary dysentery can exhibit a chronic form from which various organisms of the Shigella group can be isolated, and chronic diarrheas due to certain members of the Salmonella group have been reported. Whether or not chronic diarrhea in infants and children can be due to other enteric bacteria is a question. In this connection, Hansen[4] in a study or rectal swab cultures from infants with diarrhea and from control subjects in Texas found that, "where periodic or repeated cultures were made, often, it was noted that as Salmonella and Shigella decreased in the stools, the isolation of Proteus colonies increased. As diarrhea persisted, Proteus species were more apt to be isolated no matter what the initial findings had been. . . . . The same observations were made regarding Pseudomonas." It may well be that some cases of acute enteritis due to known pathogens may become chronic by virtue of the action of secondary invaders. The persistence of diarrhea into a chronic course associated with malnutrition and chronic parenteral infection has been observed by many[8], but here again the etiological relationship is doubtful. The theory that hidden mastoid infections were a cause of gastroenteritis was once widely ac-

Presented before the Section on Pediatrics, 114th annual meeting, Illinois State Medical Society, Chicago, May 19, 1954.

cepted, but after a multitude of myringotomies and mastoidectomies were performed with no appreciable change in the course of the gastroenteritis, the validity of this theory was questioned so that at present many investigators feel that the role played by parenteral infections has been over emphasized in the past. It may well be that the role of parenteral infections in the production of both acute and chronic diarrhea has been rendered insignificant by the use of antibiotics.

Since chronic diarrhea of bacterial etiology is a non-entity in our practice, and since the records of the Illinois Department of Public Health do not show information regarding the incidence of chronic diarrhea of bacterial origin, an effort was made to obtain information regarding such incidence by means of a brief questionnaire sent to the members of the Illinois Chapter of The American Academy of Pediatrics and to a few members of the American Academy of Pediatrics in practice outside the State of Illinois. A total of 239 letters were mailed. There were 166 returns, and of these 9 did not tabulate answers to the questions, which were:

(1) Aside from chronic ulcerative colitis and regional ileitis, do you see any *chronic diarrhea* in infants or children of bacterial etiology?

(2) Aside from chronic ulcerative colitis and regional ileitis, approximately how many cases of *chronic bacterial diarrhea* have you had in practice during the past 5 years?

108 pediatricians stated they do not see chronic diarrhea of bacterial etiology, and have had no cases of chronic bacterial diarrhea in their practices during the past 5 years.

10 pediatricians stated they do not see chronic diarrhea of bacterial etiology, yet they then tabulated a total of 47 cases of chronic bacterial diarrhea in their practices during the past 5 years. This incongruity is commented upon further on.

39 pediatricians stated that they do see chronic diarrhea of bacterial etiology in their practices and tabulated a combined total estimated number of between 215 and 257 cases of chronic bacterial diarrhea in their practices during the past 5 years.

All 9 of the pediatricians from out of the State of Illinois, selected at random in Iowa, Tennessee, Mississippi and Georgia, reported that they do not see chronic diarrhea of bacterial etiology and have had no cases of chronic bacterial diarrhea in their practices during the past 5 years.

While these figures are in some respects revealing, they are certainly not of any real value for statistical purposes for several reasons:

1. There is an apparent difference in interpretation of the term chronic.
2. Several pediatricians evidently tabulated cases as being chronic bacterial diarrhea on the basis of response to therapy rather than on the basis of stool cultures.
3. In private practice stool cultures for bacteria may not often be made.
4. It seems apparent that some pediatricians may have included chronic diarrhea due to many causes other than bacteria in their estimated number of cases.

One can scarcely draw any conclusions from the results obtained with this questionnaire with the possible exception that the majority of pediatricians in private practice in the State of Illinois do not see chronic diarrhea of bacterial etiology. It is of interest to note that all of the few out-of-state pediatricians who received the questionnaire replied and reported that they do not see cases of chronic diarrhea of bacterial etiology in their practices.

2202 18 Avenue

BIBLIOGRAPHY

1. SCHUMAN, L. M., Deputy Director Div. Prev. Med. State of Ill. Dept. Pub. Health. Personal communication.
2. "The Bacteriology of Infectious Diarrhea" MUSHIN, Med. J. Aus., Vol. I, 428, 1952.
3. "Acute Gastroenteritis" WOLFISH, J. of Ped. **43**: 675, 1953.
4. "Rectal Swab Cultures from Infants with Diarrhea and from Control Subjects" HANSEN, A. E., presented at the VII International Pediatric Congress, Havana, Cuba, Oct. 10-17, 1953.
5. CRAWFORD, K. P., "Diarrhea in Infants and Children," J. of Kentucky State Med. Assoc. **51**: 425, 1953.
6. FLOYD, THOS. M., "The Incidence of Shigella Organisms in A Group of Egyptian Village Children," Am. J. Trop. Med. and Hygiene, **3**: 294, 1954.
7. DUBOS, R. J., "Bacterial and Mycotic Infections of Man." 2nd Ed. Lippencott, 1952.
8. FRIEDMAN, A., "Experiences in Two Hundred Eighty-Nine Cases of Infantile Diarrhea in A Nutritionally Deficient Group of Infants," Am. J. Dis. Child. **85**: 675, 1953.
9. MITCHELL-NELSON, Textbook of Pediatrics, 5th Ed., 1950. Saunders.

Virus Diarrhea

W. R. Elghammer, M.D., Danville, Ill.

THE role of viruses in the etiology of diarrhea in infants and children can not be definitely stated today. Even though the tissue culture technique has been used for about 50 years and we now have elaborate tools such as the ultracentrifuge and electron microscope our present knowledge of virology is only the beginning of what will be known in another decade.

This diverse group of intracellular, highly obligate parasites known as viruses are not today conspicuously associated with diarrheal diseases. The viral diseases of polio, rabies, and encephalitis may have diarrhea associated with them in the early stages, but it is not a common symptom. Sabin[1], in a systematic search for the virus of poliomyelitis in the human body, found it is present in almost every portion of the alimentary tract, although it apparently did not produce specific lesions. Measles, rubella, chicken pox, and mumps produce characteristic lesions of the mucous membranes of the mouth and viruses may be recovered from the alimentary tract, but diarrhea rarely occurs. The common cold, our most widespread virus disease, is more often associated with constipation than diarrhea.

Most studies show that in over ½ of all patients with diarrhea the etiologic agent is never found. The report of Wolfish[2] of 518 patients with diarrhea is a good illustration. He found that 40 % had parenteral infections such as upper respiratory infections, otitis media, pulmonary infections and pyogenic skin diseases and in only 4.4% was it possible to recover the pathogenic agents by culture. The remainder or 55.6% were due to suspected, but not proven, enteral infections. It is in this latter group that viruses may someday be proven to be an important agent. However, the problem is more that the fact that virology requires a detailed and expensive laboratory technique limited to large research centers. During the past few years strains of bacteria, especially of E. Coli, that were previously thought to be non-pathogenic have been shown to cause diarrheal epidemics. It is also possible that invasion of the gastrointestinal tract by any microorganism new to the young host may cause diarrhea until immunity occurs.

Light and Hodes[3] reported the first apparently successful isolation of a filterable virus from the stools of infants suffering from diarrhea of the newborn. Calves were infected intranasally with stools gathered from 4 separate epidemics of varying severity and a bloody, mucoid diarrhea resulted. Successive passages were readily accomplished in calves and after an incubation period of 2 to 5 days a clinical disease occurred similar to the original infection produced by intranasal inoculation of the infants' stools. This disease proved to be of a relapsing nature, lasting as long as 54 days with an average of 21 days. Following recovery large doses of active material failed to cause the disease.

The virus of infectious hepatitis[4] has been transmitted to human volunteers by feeding them material obtained by duodenal drainage from infected individuals and in this disease diarrhea is a common symptom.

The syndrome of nausea, vomiting and diarrhea lasting 24-72 hours, commonly referred to as the "flu," is well known to all of us. This has long been considered to be of viral etiology, but no filtrable agent has been recovered. However, in a study of such an epidemic in Philadelphia[5] involving 20% of the student body of Jefferson Medical College the disease was transmitted to medical student volunteers by inhalation of a stool filtrate.

The most extensive work on the virus etiology of diarrhea in infants has been carried out by Buddingh and Dodd[6]. They studied infants with

Presented before the Section on Pediatrics, 114th annual meeting, Illinois State Medical Society, Chicago, May 19, 1954.

stomatitis who were irritable and refused to eat, but usually had no fever. On examination, the inner surface of the lower lip, anterior margin, under surface of the tongue and occasionally the gums were fiery red. Early in the disease small vesicles were present on the tongue and later the mucous membrance desquamated and bled easily. Many of the infants had a mucoid diarrhea which lasted 3 to 10 days, but in several cases one or more relapses occurred over a period of at least 2 months; in one patient it lasted for more than 7 months. The disease was contagious and had an incubation period of 3 to 5 days. An epidemic soon broke out in the newborn nursery and in spite of strict isolation precautions 16 of the 30 infants in the nursery developed diarrhea. Subsequently several epidemics in newborn nurseries in the area occurred, usually with a low mortality among full term infants, but as high as 80% among premature infants. When death occurred early in the disease the only lesions present were in the gastrointestinal tract.

The stomatitis has occasionally been noted in older children exposed indirectly to sick infants and has occurred in nurses, medical students and doctors caring for affected children and in one of the investigators through accidental inoculation of infected material into his mouth. A few adults who showed no lesions or symptoms of illness have been found to be carriers of the disease.

All stool cultures were negative for the usual intestinal bacterial pathogens. Because at first the disease was thought to be an atypical form of primary herpetic stomatitis, the same method of identification, namely, transfer to the cornea of the rabbit, was followed. Mild corneal lesions resulted and these could be reproduced by further inoculation of a filtrate from the ground corneas, but the lesions were not typical of herpes virus.

Cultures of the areas of stomatitis were negative for pathogenic bacteria and on corneal transfer.

The phenomena of immunity in rabbits and virus neutralization by human convalescent serum consistantly occurred. No typical corneal reactions occurred from inoculations from 100 controls including some patients with stomatitis and diarrhea of varied etiology.

The fact that there are so few instances where a virus has been recovered from a patient with diarrhea and proven to be the etiologic agent by either propogation in laboratory animals, development of inclusion bodies in infected tissues, or the development of specific antibodies in the human attests to the difficulty of the task. Perhaps in the near future new techniques of virus and bacterial identification simpler and more sensitive than that available today will reveal the etiologic agent of a large proportion of the present 55% of patients with diarrhea of unknown etiology. Only then will we be abe to state the relative importance of viruses and bacteria in the etiology of diarrhea.

Bibliography

1. Sabin, A. B.: J. Mt. Sinai Hosp. 11,185, 1944.
2. Wolfish, Martin G.: J. of Pediat. **43**:675, 1953.
3. Light, J. S., and Hodes, H. L.: Am. J. Pub. Health **33**:1451, 1953.
4. MacCallum, F. O., and Bradley, A. H.: Lancet **2**:228, 1944.
5. Reimann, H. A., Price, A. H., and Hodges, J. H.: Proc. Sol. Exper. Biol, and Med. **55**:233, 1944.
6. Buddingh, G. J. and Dodd, K.: J. Pediat. **25**:105, 1944.

The Rh Problem in Obstetrics

Joseph J. Mullen, M.D., Chicago

THE practicing physician is faced with the problem of providing the best treatment for the pregnant Rh negative patient. This includes prenatal care, delivery and postpartum management, and, in addition, the best treatment for the newborn.

With the discovery of the Rh factor in 1937, through the aid of antirhesus immune serum, there followed voluminous literature on every phase of this new blood type. It would be well nigh impossible to stay abreast of the countless articles on this one subject alone. The public press via newspaper and magazine articles featured many of these scientific studies. Often they made interesting and sometimes spectacular reading. Our patients naturally became aware of the Rh factor, although they were usually rather confused on the subject. Thus, we find pregnant patients making inquiries. An air of apprehension is easily detected in many of these patients. Unfortunately, articles featuring high speed dashes with police escorts for rare Rh negative blood make the front page. It is spot news and the newspapers cannot properly be criticised for treating it in this manner. For the physician, however, this has added an emotional problem to the management of these patients.

It is important that we be prepared to answer the questions of these patients and to reassure them wherever possible. Patients are not particularly interested in statistics when applied to them as individuals. In the light of accumulated knowledge over the past fifteen years we are able to offer certain information, and this, I believe, should be done. The hidden fear and sometimes near hysteria of many of these patients should be allayed.

We know that approximately 15% of our pregnant patients will be Rh negative. Some of those who are negative will be married to Rh negative males through pure chance. Rh negative individuals are homozygous and if they intermarry produce Rh negative children. We also know that about 13% who are Rh negative will be married to Rh positive husbands. It is with this 13% that we are most concerned. This statement is not meant to imply in anyway that we are not properly concerned for all of our pregnant patients, especially those with other complications such as the ever-important toxemias.

Accepting the theory that the Rh factor is inherited as a simple Mendelian dominant, we could expect 50% of the Rh positive husbands to be homozygous and 50% to be heterozygous. The homozygous husband is a genotype of two identical genes. Thus, all children of this marriage will be Rh positive. The heterozygous husband is a genotype of two different genes. Half of the children will be Rh positive and half will be Rh negative.

I am not suggesting that we go into a dissertation on the serology and genetics of the Rh-Hr types with the patient. After the genotype of the husband has been determined, a simple graphic explanation would be appreciated by the patient.

The Rh negative mother may ask if she is immunized, thinking that if she is that a more favorable condition exists. Immunity as we commonly use the word implies a protective mechanism. The term "sensitized" is the more correct word in this condition. An Rh negative female becomes sensitized in one of three ways. Introduction of Group specific Rh positive blood at some time in her life is the most potent source, either by transfusion, or the intramuscular route, and pregnancy with an Rh positive fetus. Minute amounts of blood may sensitize the patient. Therefore, we may find that the patient will

Presented before the Section on Obstetrics and Gynecology, 114th Annual Meeting, Illinois State Medical Society, Chicago, May 18, 1954.

have an antibody titre with her first pregnancy.

It is of the utmost importance to see that the Rh negative female patient who is to receive a transfusion shall have only Rh. negative blood. In the event of an emergency where there is not time to determine grouping, Rh factor and cross matching, then only Group O Rh negative blood should be used. If this is not available, then Group O Rh positive is sometimes used. The danger of sensitization must be weighed against the possibility of death from bleeding. Other substitutes have been suggested, such as pooled plasma, and plasma expanders. None of these is without potential danger. The use of Liquid Normal Human Plasma as prepared under the combination of ultra-violet irradiation and prolonged room temperature storage is a most effective product. This is available through Michael Reese Research Foundation.

Other information available during the course of the pregnancy is the antibody study of the mother's blood. There is disagreement as to the value of these determinations. There is evidence that hemolytic disease of the newborn has been present with low antibody titre. There is also evidence that an apparently normal fetus has been delivered where the antibody titre has been relatively high. It has been suggested by Wiener that this can be explained on the basis of avidity of antibodies, i.e. the degree of affinity between an antibody and the corresponding antigen or blood factor. Antibodies of low avidity produce less damage to erythrocytes. As a rule, with a rising titre of univalent or blocking antibodies one may anticipate hemolytic disease of the newborn to some degree. We may observe the delivery of an apparently normal fetus, but serial blood studies of the untreated newborn will reveal a progressive drop in R.B.C., the appearance of nucleated R.B.C.'s, lowered Hb and increasing icterus and a possible Kernicterus. In private practice at the present time I shall continue to secure antibody titre determinations. From observation of a small series of patients, my conclusions are compatible with those of other clinics.

Numerous methods have been advocated for treating the Rh negative mother during the course of the pregnancy. When the patient is sensitized, the rationale has been based on preventing or modifying the formation of additional antibodies. Some of the methods used are listed:

1. Vitamin E in 100 mgm. daily doses. The mechanism involved here is not clear.

2. Rh hapten or the specific non-antigenic portion of the Rh agglutinogen, the theory being that injections of the hapten into the mother might protect the Rh positive fetus in utero. The validity of this procedure has not been proven.

3. Ethylene disulfonate in minute doses has been used in weekly injections on the theory that it might stop the progress of antigen-antibody reaction.

4. Counter-immunizing the mother throughout pregancy with large doses of a relatively harmless vaccine such as typhoid or pertussis has been suggested by Wiener. Limited trials by Unger has shown some decrease in evidence of sensitization. However, the method seems too tedious for general application.

5. Cortisone, as was to be expected, appeared in the literature. A recent study by De Costa and associates led to these conclusions:

a. the administration of cortisone to the Rh negative sensitized mother has no influence on the antibody titre.

b. There is no influence on the salvage rate of the erythroblastotic fetus.

c. and in addition, it is of interest to record the development of acute (mild) pre-eclamptic toxemia in a patient during cortisone therapy.

Termination of the pregnancy prior to the expected date of delivery has been advocated to prevent additional damage to the fetus. Here we are introducing the additional hazard of prematurity and immaturity. If elective Cesarian Section is the method of choice of terminating the pregnancy we are faced with the increased fetal mortality rate attendant on Cesarian Section itself plus that of varying degrees of prematurity. The only indication for Cesarian Section must be a sound obstetrical reason, and not because of a rising titre alone. Induction of labor through amniotomy or medical induction with intravenous pituitrin is less hazardous to the fetus. Maternal conditions must be favorable to induction. An unripe cervix will complicate the induction.

A figure that is frequently found in the literature is that approximately 5% of Rh negative women married to Rh positive husbands will

have one or more erythroblastotic infants. This has been established in large series at Baltimore, Toronto and Oslo. Excluding those patients who are sensitized by transfusion, we find that approximately 5% of all Rh negative women will show the presence of antibodies. We accept the fact that fetal cells must gain access to the maternal circulation to sensitize the mother. Whether this is a physiological or pathological leak across the placental barrier has not been established. The normal placenta with its huge surface of villi in contact with the maternal circulation could explain leaks across the placental barrier. The placental villus has only a single layer of syncitial cells and a layer of endothelium between the fetal and maternal circulation. If it were physiological, would we not expect a higher percentage of sensitized Rh negative mothers? Whether sensitization of the mother by the fetus can be reduced will no doubt be investigated further. The work of Gainey and associates in this respect is of interest. A group of sensitized patients was studied in a search for possible common factors to suggest the manner in which the patients became sensitized and whether there might be induced pathology. Among the factors in this group which recurred in previous history were included: manual removal of the placenta, Cesarian Section, induced labor, traumatic 3rd stage, traumatic deliveries, abortion with dilitation and curettage, induced abortion and shock therapy. All of these factors could alter the physiology of the placental barrier, thus allowing fetal cells to enter the maternal circulation. What part will conservative care and non-traumatic management of the Rh negative patient play in prevention of iso-sensitization? A careful study of the history of prior pregnancies is advocated.

There is a wide variation in the antigenic potency in the various Rh factors. Variation in the capacity of the mother to form antibodies is a factor as shown by Donohue and associates. Transfusion is the most potent method of sensitization and still it has been shown that only about 50% of a group of Rh negative male volunteers could be sensitized by injection or transfusion of Rh positive blood. This experiment, of course, could never be applied to females, but we could assume the same result.

To date we have little in the way of definitive treatment for the mother during the pregnancy. Our greatest progress has been made in the care of the newborn where there has been a sharp decrease in fetal mortality from erythroblastosis fetalis. This can be ascribed to intelligent pediatric care. The information made available by antibody studies during the pregnancy will help us to predict the degree to which the fetus is involved. At the time of birth a Coomb's test will reveal whether the fetal red cells are coated by Rh_o or other antibodies. A positive test is generally pathognomonic for erythroblastosis. Blood counts and Hb determination should be done immediately on the newborn.

Transfusion with blood that is compatible with the maternal iso-antibodies apparently is responsible for the reduction in fetal mortality. There are two methods available. Multiple simple transfusions and replacement transfusion. The proponents of total exchange of blood have claimed marked advantages for this method. Donohue and associates have experience with two significant series of over 200 infants in each series. With the exception of a higher percentage of Kernicterus survivals with multiple transfusion, their over-all results were satisfactory with either the multiple or the exchange transfusion method.

There have been many techniques suggested for exchange transfusion, all of which have their merits. A V-shaped incision in the radial artery at the wrist for bleeding and a blunt 20 gage needle in the saphenous vein at the ankle for injection is a technique that can be mastered. Heparin given at the start will aid in bleeding the infant. 1 c.c. of 10% Calcium Gluconate is given after every 100 c.c. of blood to counteract the effect of the citrate in the donor flask. It has been estimated that a transfusion of 500 c.c. of blood or about twice the newborn's blood volume will effect an 85% exchange of blood. With this routine the greater part of the damaged red cells will be removed, thus offering a more favorable prognosis for the newborn.

The practicing physician has certain objectives in his relationship with his patient, which to him are all-important. These include proper prenatal care, the delivery of a normal healthy infant, a normal healthy mother with an uneventful puerperium and an awareness of the emotional status of the patient during the pregnancy. The

physician's explanation to the patient of the information available concerning her status will result in most cases in a well-adjusted and appreciative mother.

BIBLIOGRAPHY

1. Donohue, W. L., Mullinger, M. A., Cook, E. G. and Snelling, C. E. American Journal of Obstetrics and Gynecology. Vol. 67, No. 2, 1954
2. Low, D. M., American Journal of Obstetrics and Gynecology. Vol. 67, No. 2, 1954
3. Wiener, A. S.: An Rh — Hr Syllabus New York, 1954, Grune and Stratton
4. De Costa, E. J., Gerbie, A. B. and Potter, E. L., Obstetrics and Gynecology. Vol. 3, No. 2, 1954
5. Gainey, H. L., Nicolay, K. S., Keeler, J. E. and Doyle, M.E. Rh Iso-Immunization. Obstetrics and Gynecology. Vol. 3, No. 2, 1954

‹‹‹ ›››

Treatment of Chronic Lupus Erythematosus with Atabrine and Chloroquine

Richard B. Stoughton, M.D., Chicago

THIS talk will be confined to the value of atabrine and chloroquine in the treatment of chronic lupus erythematosus, the toxic manifestations of these drugs, their comparative chemistry and dosage schedules, what little is known about them at this time.

The spontaneous course of any disease should be well understood before any therapy for that disease is evaluated, and quite surprisingly some reports indicate that 50% of cases which first develop chronic lupus erythematosus will spontaneously improve and some 25% of these may go on to complete spontaneous resolution. Our own experience suggests that a smaller percent undergo spontaneous resolution.

With all types of therapy that were available before atabrine and chloroquine, Sequira reports 30% cured, 30% improved and 40% unchanged.

Several recent reports and our own results indicate that chlorquine and atabrine give somewhat better results than would be expected either from the natural course of the disease or with any other form of therapy. Also in favor of chloroquine and atabrine, and this is most important, is the fact that these encouraging results were obtained for the most part in cases which had previously been resistant to all other methods of treatment (gold, bismuth, pantothenates, Vitamin E, CO_2 and other agents used in treating chronic lupus erythematosus).

What has been most impressive about chloroquine and atabrine is the way a chronic discoid patch of lupus erythematosus may, after years of staunch resistance to all treatment, suddenly undergo resolution.

Our results in the treatment of lupus erythematosus with chloroquine and atabrine are represented in Table 1 and are as follows:

TABLE 1
TREATMENT OF CHRONIC LUPUS ERYTHEMATODES

Chloroquine	
Cleared completely	6
Substantial Improvement	6
Slight Improvement	7
No Improvement	6
Total	25
Atabrine	
Cleared completely	5
Substantial Improvement	4
Slight Improvement	5
No Improvement	5
Total	18

*From the Section of Dermatology, Department of Medicine, University of Chicago

**Assistant Professor of Dermatology, University of Chicago, School of Medicine

Presented before the Section on Dermatology, 114th Annual Meeting, Illinois State Medical Society, Chicago, May 19, 1954.

(a) Half the cases receiving chloroquine showed definite and worthwhile improvement while the other half ended up with little or no improvement. Twenty-three of these twenty-five cases had already received extensive treatment with other drugs without significant change in the lesions. Six of these twenty-five cases have cleared completely and except for minor flare-ups four have remained in remission for over eight months without any further therapy while the other two relapsed and required more treatment. Two of these prolonged remissions had received no previous therapy and represented relatively early lesions.

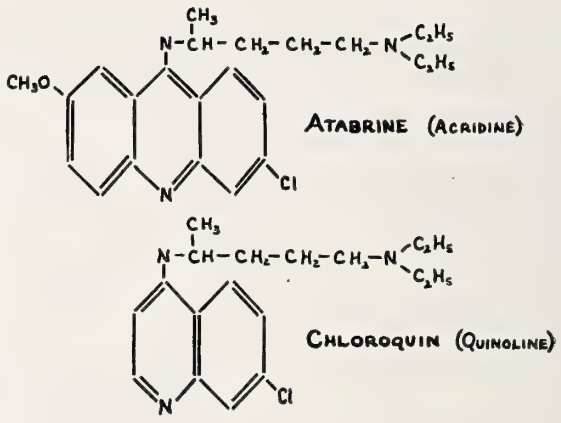
(b) The thirteen cases which showed substantial or slight improvement reached a point where no more improvement could be obtained by further administration of chlorquine. However, after the drug was discontinued, many of these cases relapsed to their former state. Readministration of chloroquine again effected a favorable response except in two cases which resisted further medication with this drug. In two cases which would respond no longer to chloroquine, gold salts improved the lesions.

(c) It may be that continuous administration of chloroquine or atabrine would prevent most relapses but we don't know how long to continue the drug or in what doses it should be continued or in which cases it should be continued.

(d) In our series of cases the effect of chloroquine is as good as that of atabrine. A recent article by Harvey and Cochrane agrees with this. The concensus seems to be that chloroquine is every bit as good as atabrine. The added advantage is that chloroquine is less toxic and does not stain the skin yellow.

A summary of the recent reports of treatment of chronic lupus erythematosus with atabrine and chloroquine reveals the following points:

1. 60 — 70% of cases of chronic lupus erythematosus respond very favorably.
2. 10 — 30% are completely arrested.
3. There are many warnings against using these drugs in subacute lupus erythematosus.
4. If any benefit at all is to be derived from the drug, it should begin within six weeks
5. However, if no benefit is seen in six weeks and a higher dose can be tolerated, it is worth trying.
6. The superficial (erythema perstans) type of chronic lupus erythematosus responds very well to treatment with atabrine and chloroquine.
7. After withdrawal of the drug, the relapse rate is very high; but what the maintenance dose should be and how long it should be given has not been established.
8. The overall opinion seemed to be that though the antimalarials, atabrine and chloroquine, are far from perfect, they are still better than any other method in the therapy of chronic lupus erythematosus.



It is of interest to study the chemical structure of these compounds. Figure 1. Atabrine is an acridine compound and chloroquine being a quinoline is closely related. Pharmacologists believe that both compounds are effective in malaria because of the quinoline parts and such might be the case for lupus erthematosus also.

Chloroquine is usually dispensed as the diphosphate salt. Thus 500 mgm. of the phosphate salt represents about 340 mgm. of the active base, 160 mgm. being represented by the pharmacologically inactive phosphate. Atabrine is dispensed as the hydrochloride salt: 300 mgm. of the salt representing about 270 mgm. of active base.

Thorough toxicity studies were done on these drugs before they were introduced as antimalarials. Most of the human volunteers for these toxicity studies were inmates of the Illinois State Prison at Joliet. Also, there is a backlog of experience in actual army field tests with both of these drugs but with smaller doses than are given in lupus erythematosus. Table 2.

TABLE 2
TOXICITY OF ATABRINE & CHLOROQUINE

Chloroquine	*Atabrine*
1) Visual difficulties 50%	1) Yellow staining of skin (100%)
2) EKG changes (minimal) 60%	2) Leukopenia (unusual)
3) Weight loss (minimal) 15%	3) Gastroenteritis (unusual)
4) Headaches (mild) 15%	4) Depression (mild)
5) Lichenoid dermatitis .....(Rare)	5) Eczematous or lichenoid dermatitis

Overall toxic manifestation for chloroquine far less than atabrine and avoid yellow discoloration of skin.

Though chloroquine and atabrine are capable of eliciting many toxic symptoms, they are usually not serious.

There is a slight nausea with chloroquine occasionally but this can be well controlled by giving the pills after meals along with a little phenobarbital a half hour before meals.

Neither atabrine nor chloroquine has any effect on uterine function and can be given during pregnancy.

A thorough review of the literature on the subject of dosage of these drugs in lupus erythematosus reveals a very inadequate understanding of (1) maximum tolerable dose, (2) how much of the drug can be given for how long a time without cumulative toxic effects (3) length of time administration of the drug is necessary to prevent relapses or even whether relapses are preventable by prolonged administration of the drug. Table 3.

TABLE 3
DOSAGE OF CHLOROQUINE

Initial: 750 mgm. every day for first 10-14 days.
Maintenance: 250-500 mgm. every day indefinitely.
Serum level:
a) Maximum level reached in 30 days on daily dose of 500 mgm.
b) Detectable amounts remain in serum 30 days after chloroquine is withdrawn from therapy.
c) Clinical response follows serum concentration rather closely.

Chloroquine given at the rate of 500 mgm. of base per day (i.e. about 750 mgm. of diphosphate salt) requires 30 days to reach maximum concentration in serum. Also detectable serum levels of chloroquine are found 30 days after chloroquine has been discontinued. It is also of interest that tissue levels of chloroquine are 300 times those of serum when they come to equilibrium. These facts might well explain why cases of lupus erythematosus don't start to relapse until three to four weeks after discontinuance of chloroquine.

500 mgm. of chloroquine base per day for a year have been given to adult males without ill effects (this is about equivalent to about 750 mgm. of the diphosphate salt). Obviously the patient with lupus erythematosus is not a normal adult but this toxicity study does suggest that we can use higher doses of chloroquine than we are now using.

In view of these data gathered from various toxicity studies and our own experiences, it is recommended that for the average adult with chronic lupus erythematosus an initial dose of 750 mgm. of chloroquine can be given for 10 to 14 days succeeded by 250-500 mgm. per day for an indefinite period.

Periodic checks of the white blood count, differential and urine should be performed every two weeks throughout the treatment period.

SUMMARY

1. Atabrine and especially chloroquine are the current drugs of choice in the treatment of lupus erythematosus but by no means the only ones to be used.
2. Chloroquine is preferable to atabrine because it is less toxic per effective dose, does not stain the skin yellow, and is at least as effective in therapy.
3. Further cautious experimentation with chloroquine is indicated with a view to higher doses for longer periods of time.
4. Indefinite maintenance doses may have to be given to the majority of cases in order to maintain established benefit from the drug.

DISCUSSION

Stanley E. Huff, M.D., Evanston, Ill. Dr. Stoughton has given us an excellent summary of a new use for these drugs in a disease which is ordinarily quite resistent to treatment.

My experience with atabrine and chlorooquin is rather limited and my results so far have been good only in two cases of the superficial type of L. E. Both have responded promptly to atabrine but have replapsed

twice when the drug was discontinued. The yellow or bronze color produced by atabrine has been of little concern to any of the patients receiving it.

The incidence of reactions involving the skin, hematopoietic, gastrointestinal or central nervous systems or liver is probably no more frequent than that from heavy metals; however, it is advisable to obtain blood counts and hemoglobin levels periodically.

The mechanism of action of these drugs is unknown but, since they are effective in sunlight dermatoses also, they may be related in some way to reduction in photosensitivity. Recent reports of their effectiveness is certain atrophies of the skin suggest still another mode of action.

I have nothing further to add except to call attention to the fact that atabrine was first used in L. E. by a Russian and to repeat Dr. Rattner's observation that it is unusual that a Russian should discover something which tends to make a lesion less red.

‹‹‹ ›››

Ocular Manifestations in the MENTALLY DEFICIENT

L. B. Kamenetz, M.D., Dixon

THE title of my paper is somewhat misleading. It should read: *"Some* Ocular Manifestations . . .". You will understand that it is impossible to cover in 20 minutes a subject that would normally require hours if I wished to go into detail. This, however, is not necessary, since I am talking here before a group that is not particularly interested in neuro-ophthalmology as a specialty but would like to get acquainted with ocular signs which might help to confirm a neurological diagnosis or might throw light on the etiology of certain diseases. Again I do not intend to give you an extensive scientific talk; I would rather consider the practical aspects and utilize the experiences which I have gained during many years of dealing with mentally retarded persons.

Ocular manifestations in this type of patient are of frequent occurrence. This is not surprising when we realize that the development of vision in a human being is a complicated affair. It involves not only the eyeball but also the growing brain. The newborn infant has little ability to fixate an object with his eyes. The macular fibers as well as the visual nerve pathways in the brain do not function too well until the age of about 5 months. It is only between the 8th and 12th week after birth that the optic nerves become myelinated and not until the age of four to five months that the fovea centralis is completely medullated. The coordination of ocular movements which depends on reflex mechanisms within the brain becomes established at about 5 months. These facts are important in the consideration of squints which we so often see in the mentally defective persons of all types.

Now let us return to practical considerations and here again I must tell you a few words about eye examinations as they should be conducted by a neurologist or psychiatrist:

Do not look just at the eyes. Throw a glance at the whole body. See if the patient is a dwarf, a spastic, a mongoloid, or a case of cerebral palsy. This will help you to determine what you should look for. For instance, if you have a child that looks like a case of gargoylism examine the cornea. If you see a definitely mentally retarded, blind infant — say 3, 6 or 12 months old; you would look for retrolental fibroplasia or optic atrophy or for retinal changes so characteristic in

Presented before the Physicians' Association of the Department of Public Welfare, 114th annual meeting, Illinois State Medical Society, Chicago, May 18, 1954.

Amaurotic Idiocy (Tay — Sachs). Look at the eyes without instruments. Is there a ptosis of one or both lids? Is there a nystagmus? Is there a lateral deviation of the eyes? Keep in mind that a ptosis can be organic, congenital, or it can be a sign of a nerve paralysis. It is almost always an oculomotor paralysis if the ptosis is bilateral and associated with a divergent squint. This is a typical picture: the eyes are half closed; the right eye looks to the right and the left eye to the left. The lesion is in the pons. If you find a ptosis and myosis in one eye think of paralysis of the sympathetic cervical chain. This I only mention casually because I saw this Horner Syndrome once in a young mentally retarded child and I wondered if it had anything to do with an optic atrophy in the same eye. Actually, the ptosis and myosis were due to a congenital tumor of the thyroid. Real lateral deviation of the eyes or paralysis of the conjugate gaze are important as indicative that there is cerebral pathology: usually some sort of lesion in the cortex or close to the quadrigeminal plate. Convergence paralysis of the eyes is common but often overlooked. At times it is an early sign of beginning Parkinson's disease, particularly if it is associated with rigidity of the neck muscles.

Examination of the cornea is very important. In *Wilson's disease* which is a progressive hepatolenticular degeneration, we see in a certain percentage of cases the so-called "Kayser-Fleisher-Scheerer Ring". This consists of green pigment and can be seen around the limbus but still in the peripheral part of the cornea. If such a ring is seen in a neurological case — with or without mental deficiency — Wilson's disease should be taken into consideration.

About half a year ago I was asked to examine the eyes in a new admission — a girl of 6 years sent to Dixon State School because of mental deficiency. The examining physician noticed that the cornea was cloudy and he was thinking of deep Syphilitic Keratitis. When the child was brought into the dispensary, I noticed that she was unusually small, her head enlarged, having a scaphoid shape. The child had a peculiar look which gave her some sort of "attractiveness". I looked at the corneae. They were not cloudy but, in general, foggy, hazy, as if covered with a fine, thin veil. This was a case of *gargoylism*. The changes in the corneae are, of course, not a result of an inflammatory process but due to a deposit of a substance consisting of protein and glycogen products. Gargoylism, as you know, is a metabolic or rather a storage disorder. The findings in the cornea together with other characteristic signs, including x-rays, confirmed the diagnosis in this case.

After examining the cornea we take a look at the iris and the lens. We might see atrophy of the iris and a mass in or just behind the pupil. This may be a congenital cataract seen often in Mongoloids, or it might be a retrolental fibroplasia seen in prematurely born children. If there is atrophy of the iris, and the membrane or mass seen behind the pupil looks as if it is deeper than where you would expect the lens to be — or if you see with a plus 10 or plus 12 lens that there are a few vessels running over the green membrane — think of retrolental fibroplasia. Of course, what you would see is a far advanced stage of this disease or the end-result of this vascular disease. The eye is lost.

Now we come to a very important examination, the *"Pupillary reaction"*. Excuse me if I talk about this "baby stuff" for a few moments. Examination of the "Pupillary reflex" can be very easy, and usually is; but sometimes one encounters difficulties and appears to be at a loss in interpreting a lacking reflex. *Real anomaly of pupillary reaction to light is of grave diagnostic significance.* However, at times we incline to assume that there is pathology where in effect there is none. If you frighten a child by throwing strong artificial light into the eyes and the pupils do not get smaller, do not be surprised. Reexamine the child in a semi-darkened room, use milder lights and try to gain the confidence of the child. Approach the eye with your light slowly and from the side. There is also the slowly reacting "tonic pupil of Adie's Syndrome", with only an apparent absence of light reaction due to a tonic contraction which relaxes the sphincter of the iris very slowly.

And now to the fundus examination (ophthalmoscopy). I am often asked what lens should be used for fundus examination. I always advise to start with "zero" — go up or go down until you see best. It is not always an easy task, and at times it is very difficult or almost impossible to examine the fundus in babies. You have to

use imagination in attracting the attention of the child to make it look in a certain direction. Occasionally we have to use general anesthesia and fixate the eyeball with an eye forceps.

I am not going to talk about the kinds of *optic atrophies* one sees in hydrocephalics, oxycephalics, microcephalics, etc. I will also skip a discussion of *papilledema* (choked disc). There are, however, several nerve diseases which cause mental deficiency associated with degenerative processes seen in the retina. First of all, in so-called *Amaurotic Family Idiocy (Tay-Sachs)*; the babies are severely retarded, blind and, in a high percentage of cases, of Jewish origin. The diagnosis of Amaurotic Idiocy can be made with certainty only when the typical retinal findings are present; otherwise, the condition can only be suspected. The disease, as you know, is characterized by a progressive degeneration of cerebral neurones which gradually results in blindness, wasting away and death. There is an accumulation of *lipoid substances* in the cerebral neurones with a characteristic ballooning of the cells and swelling of the axons and dendrons. The nucleus is displaced to the apex of the cell. The etiology is actually unknown, though there is some indication that it might be an enzyme defect analogous to phenylketonuria. Now what do we see in those cases in the fundi? We see an atrophy in the region of the macula lutea represented by a white patch, and in the center of the patch is seen a "cherry-red spot". Actually, the patch represents the sclera, the retina being destroyed. In the last eight years I saw four cases of "Tay Sachs". They were all of the infantile form; that is, of the type where both cerebral and retinal ganglion cells undergo degeneration during the first year of life. Inheritance is of the dominant variety. I never saw a case of the juvenile form in the mentally deficient. In this form the symptoms of degeneration do not make their appearance until the age of six or eight years.

Now to another neurological disorder associated with mental deficiency: the *"Laurence-Moon-Biedl Syndrome"*, where one finds pigmentary degeneration of the retina. I saw one case characterized by obesity, hypogenitalism, polydactily and *retinitis pigmentosa*. The causation of this curious disease is obscure. It is familial and consanguinity may play a part.

Lately there has been a lot of talk about mental deficiency due to *Toxoplasmotic Encephalitis*. Thus far I have seen only one case with a definite diagnosis of toxoplasmosis. To my knowledge some twenty autopsies were performed prior to 1950. No doubt the actual number of cases is much larger. This protozoal infection in children causes a granulomatous encephalitis with resulting mental deficiency. This must be considered when a healthy newborn child shows very early in life evidence of a severe cerebral illness. These children frequently have epileptic seizures. X-ray of the skull is quite typical. One sees calcifications spread over cortical areas. Eye examination may confirm the diagnosis. With the ophthalmoscope one sees chorioretinitis with "punched-out" lesions in the region of the macula but also in other parts of the retina. There are areas of degeneration — white-greyish spots with accumulation of dark pigment. Nystagmus, microphthalmos and exophthalmos have been observed. Most of the children die but if they survive they are severely retarded.

We have seen quite a number of *Sturge-Weber-Dimitri Syndromes* which belongs in the group of "phakomatoses". This congenital disease is characterized by hemangiomatosis of the skin, brain and other organs. X-ray of the brain shows typical calcifications of the cortex; one sees fine loops simulating vessels. The fundi reveal angiomatosis of different degree and not so seldom glaucoma develops in such eyes. *Tuberosclerosis* is a disease seen not too rarely. It belongs in the group of "Phakomatoses". It has many names like "Bourneville's disease", "epiloia", etc. Those children are mentally deficient; they have epilepsy and adenoma sebaceum in the face. X-ray pictures of the skull in tuberosclerosis are quite characteristic. One sees subcortical calcifications. The "tubera" or "plaques" consist of dysplastic cortical areas in which there are few normal nerve cells. There are severe changes in the eye-grounds which appear in the form of nodules of different size. Frequently the tumor has its origin at the margin of the disc. The lesions involve all the layers of the retina. They consist of long fibrillary cells which stain positively for glial fibers. The case which I saw represented a white-yellowish round mass, the borders being quite sharp. As you know, the

disease is inherited, transmitted through a single dominant gene.

There is one more eye examination which in certain neurological cases is very important: the test for the visual fields, done with a perimeter or a tangent screen. It is an absolutely necessary examination when we are looking for lesions affecting the higher visual pathways. However, this is beyond the scope of my paper.

In conclusion, let me say once more that an eye examination is a part of a neurological examination. In the evaluation of mentally retarded babies and children it is a necessary measure. There are a few diseases in which a diagnosis is almost impossible without it.

‹‹‹ ›››

Accommodation and Problems In Ocular Motility

Beulah Cushman, M.D. and Devereaux Jarratt, M.D., Chicago

ACCOMMODATION is the ability of the eye to increase or decrease its focusing power by increasing or decreasing the power of its lens. Two theories, Helmholtz and Tscherning, with modifications, attempt to explain the mechanics of this flexability inherent in the lens. It is not within the scope of this paper to discuss the merits of either theory but to accept that the lens, by increasing its anterior curvature and thickness, changes toward a stronger refracting media.

At birth, approximately 18 diopters of accommodative ability is present in the lens, and this ability gradually diminishes throughout life until at the age of 60 only two or three diopters remain. These are power diopters and can be measured by the minus lens that will neutralize this accommodative effort or by a measurement of the distance from the eye that a clear image is projected. They are therefore, expressions of the elasticity of the lens. Van Der Hoeve and others write of a ciliary unit or Myodiopter, which is always greater in a latent form than the dioptric affect of the physical or lenticular form. In explanation, consider an individual age 32, who has only nine diopters of physical accommodation left in each eye and can therefore when using maximum accommodation see an object clearly at eleven centimeters when using one eye. When allowed the use of two eyes the convergence effort calls out the latent ciliary effort and approximately one to one and one-half more diopters of physical accommodation can be measured. We mention this purely to show that if the lens were deprived of all accommodative effort the ciliary energy can to some extent stimulate and be stimulated by convergence.

When parallel rays of light strike the eye and it is emmetropic, images are focused on the retina without accommodative effort. This has been termed the far point of that eye. If, however, the rays of light are diverging, coming from a point source nearer than infinity, then sufficient accommodation must be exerted by the eye to focus the image, the amount ever increasing as the object approaches the eye. The point at which maximum accommodative effort is being exerted and a clear image is focused is known as the punctum proximum. If this emmetropic eye is in the age group of the twenties, it would have approximately ten lenticular diopters of accommodation and its near point would be 5 cm. Now to consider ametropia. In hyperopia the accommodation must be used for all distances; thus there is no far point unless we consider one that is beyond infinity, and

Presented before the Section on Eye, Ear, Nose and Throat, 113th Annual Meeting, Illinois State Medical Society, Chicago, May 19, 1953.

the near point must in the same age group be more distant than that of the emmetrope. In myopia, divergent rays are focused, so necessarily the far point is closer than infinity and the near point nearer the eye than an emmetrope of its age group.

The preceding has dealt with only the fluid dioptric system of the individual eye, but since the psyche unifies the impulses it receives from the two retinae we must consider the integration of the systems of the two eyes.

The optical axes of the two eyes are approximately 6 cm. apart and for similar images to be presented to corresponding retinal receptors the eyes at all distances, except infinity, must be converged. The distance of the object of regard determines both the amount of convergence and accommodative effort necessary to present clear images to corresponding points of the two retinae.

This synergism between accommodation and convergence is strong but not rigidly fixed. There is a normal relationship between the two and this is readily demonstrated in the emmetrope, for when the object of regard is situated one meter distant, the accommodative effort is one diopter and the convergence effort is one meter angle. In explanation, one meter angle is equivalent to six prism diopters, for it requires a six diopter prism to converge a ray of light six centimeters at one meter distance. The accommodative convergence relationship continues to the punctum proximum.

Table T

The Myo-Dioptric System of the Eye

At *6M*	No accommodation — no convergence. Visual axes parallel.		
At *1M*	Accommodation 1	Converges 1 meter angle	(1 meter angle = 6△) 60 P.b.
At *50cm*	Accommodation 2	Converges 2 meter angles	(12△)
At *33cm*	Accommodation 3	Converges 3 meter angles	(18△)
At *25cm*	Accommodation 4	Converges 4 meter angles	(24△)

In the ametrope a different unit relationship of accommodation and convergence exists. To show this, consider first a hyperope of +3.00 error, here at infinity +3.00 diopters of accommodation must be used at the same time and the eyes must remain parallel. At all distances to the near point the +3.00, in addition to the amount necessary to focus at a certain distance, is required for clear vision. At all distances, convergence must be the same as in the emmetropic eye. At one meter, this pair of eyes must each accommodate four diopters and have a prism convergence of six diopters. Actually 24 prism diopters of convergence are stimulated by the four diopters of accommodation but 18 diopters are suppressed. Therefore, unlike the emmetrope with a one to one ratio of accommodation and convergence this individual has a four to one ratio which must be retained if binocular single vision is to be had. As the refractive error increases more strain is placed on the accommodative convergence relationship. If the mechanism initiating binocular vision is weak, then the use of the eyes together will fail and convergence of one eye will result.

The myope with a far point closer than infinity need use no accommodation until this point is passed, but must call on convergence for binocular single vision. Here a —3.00 myope will need no accommodative effort at 1/3 of a meter but will have to converge three meter angles, 18 prism diopters, giving him an accommodative convergence ratio of 0 to 3 at this distance.

These ratios are held in the ametropic eyes if single binocular vision is to be had. If the accommodative error is small, then the strained convergence accommodative relationship may be suppressed, as a phoria; but if large, a tropia may develop. These phorias and tropias may be fairly accurately measured by means of the screen test with prisms. These measurements when taken for distance and near, (six meters and 25 cm.) with the near point of convergence, will show whether one is dealing with a convergence or divergence anomaly. For in the uncorrected moderate hyperope using accomodation in excess of convergence when screened, more esophoria for near than far will be measured with a very close near point. The greater the amount of accommodation used the more the measurement in prism diopters and the closer the near point. If the accommodative effort does not improve the image the eyes may forego this effort and no stimulae to converge is received, the eyes then diverge.

The moderate uncorrected myope, using con-

vergence in excess of accommodation, when measured and screened will often show a convergence insufficiency with a poor to remote near point. When the myopia is large and when convergence does not help to stimulate binocular single vision because of a blur of the image, the eyes will diverge at all distances.

In all cases of ametropia some evidence can be brought out that the normal accommodative convergence ratio has been strained and a new ratio is present. Therefore, in problems of muscular imbalance, whether phorias or tropias, the refractive error should be determined and properly corrected before seeking other causes for the malalignment of the eyes. After the proper correction has been instituted the glasses should be worn until a more normal adjustment between accommodation and convergence has developed. The period of time varies with the individual and the amount of error. On an average the full correction should be worn for three to six months before a final diagnosis is made and surgical treatment contemplated.

The portion of the malalignment of the eyes corrected by the lens is the accommodative factor; at times it is the largest part of the error and should never be minimized. In all cases of convergence excess the full plus correction should be prescribed and the near point watched, for if it should begin to recede then the plus sphere must be reduced. In all cases of convergence insufficiency the total plus refractive error should be corrected only enough to give distinct images, thus allowing a sufficient accommodative factor to be present to stimulate convergence. If after wearing the full plus correction for a period of three to six months there is very little change in the imbalance at near, with an unaltered near point of convergence, then the accommodative factor is of small importance and continued wearing of the glasses will not change the picture.

SUMMARY

The importance of evaluating the refractive error in problems of ocular motility cannot be overemphasized, and examination should be repeated at frequent intervals. The best possible visual acuity should be allowed. In those cases showing convergence excess with an unlimited near point the full plus lens should be given. The near point should be closely observed and as it shows evidence of recession, then the plus lenses should be reduced. In convergence insufficiency the total plus lens should never be given but clear vision is a must. After the refractive error has been corrected and the correction worn for three to six months a new accommodative convergence ratio will be present and will approach the normal. After this change has taken place any residual ocular imbalance must be corrected by surgery.

‹‹‹ ›››

Sudden death

Most sudden deaths in infancy, especially below the age of six months, are due to infections. True suffocation deaths are rare. Aspiration is a common agonal event but seldom is the cause of death. Mononuclear cells may be present in the alveolar bronchioles in several different conditions and are not diagnostic of pneumonia. Streptococci, staphylococci, meningococci, and E. Coli septicemia have all been shown to cause sudden death to infants. *Eldon Berglund, M.D. Suffocation: A Killer of Children. Minnesota Med. Feb.* 1955

Indications for Mitral Valvulotomy

Robert L. Grissom, M.D., Omaha, Neb.

THERE are many patients in the country today who are disabled by mitral stenosis and who can be benefited by mitral valve commissurotomy. This is a good operation, now about four years old. We are at a point where we must decide between those enthusiastic persons who wish to do the operation where it may not be necessary and those other conservative persons who may not appreciate its benefits until the degree of disability has progressed beyond the point where maximum benefit can be obtained.

From the experience of studying more than forty patients with mitral stenosis by cardiac catheterization, of whom seventeen were restudied after operation, we have concluded that a good physician with a pair of hands, a pair of eyes and a stethoscope can tell just about everything that we can. Ordinary diagnostic studies, therefore, are sufficient in most cases to determine whether or not the patient is a suitable candidate for operation.

How do we decide on selection of patients? First, the story the patient gives. It is helpful to have the patient say that he has become progressively disabled, so that formerly he could climb three flights of stairs but now finds that he has disability after one flight of stairs. Or again, if he says that he gets short of breath at those times and is seized by a paroxysm of coughing, we know that there has been congestion of the pulmonary parenchyma due to blockage by a stenotic mitral valve. Many of our patients have hemoptysis, sometimes flecks of blood or occasionally frank hemorrhage. We have not operated on any patients who have not at some time or other had some degree of orthopnea. If the patient says that formerly he was able to lie flat in bed but now he has to double up the pillow or use two or three, we know that he has progressive disease. In addition, we recognize situations in which the clinical state may be static, perhaps for five or ten years but, nevertheless, so disabling that the patient can be expected to receive benefit from operation.

All the symptoms I have mentioned are those leading to progressive or static pulmonary difficulty and it is that breathing difficulty which is the point needing most evaluation. We must be sure dyspnea is not due to neurocirculatory asthenia or obesity and reasonably certain that it is related to this pulmonary congestion, secondary to the damaged orifice of the stenotic mitral valve. Given such complaints in a patient with known mitral valvular disease, we can very nearly say over the telephone, "Surely, he needs the operation."

What about the presence of congestive failure with a large liver and ankle edema in a patient who has required mercurials? We feel that if there is a co-existing pulmonary congestion, peripheral failure is further evidence that the patient has progressed to the point of needing this kind of help, providing the disease is primarily in the mitral valve. If there is intractable peripheral failure and if, by carefully regulated low salt diet and mercurials, the failure is unrelieved, then the risk is too great to warrant the surgery.

The other thing I want to emphasize is the story the patient gives on his social and psychological background. Dr. Glover of Philadelphia has reported four postoperative psychoses after operation out of 189 patients, and we have had one recently in one of our best surgical successes, who is now as "nutty as a fruit cake." I am sure she really is not benefited.

Having listened to the patient's story, what about the cardiac findings? All of us have had patients come in for examination and we have said to ourselves, "This is a beautiful pre-sys-

---

Associate Professor of Medicine, College of Medicine, University of Nebraska, Omaha, Nebraska.

Formerly Assistant Professor of Medicine, College of Medicine, University of Illinois, Chicago, Illinois.

Presented before the Section on Cardiovascular Disease, 113th Annual Meeting, Illinois State Medical Society, Chicago, May 19, 1953.

tolic and mid-diastolic murmur." Now and then such patients are referred for surgery when they are not really sick enough to warrant it. We require clinical signs of mitral valvular stenosis plus symptoms of disability.

What about mitral insufficiency? In general, if the systolic murmur of mitral insufficiency at the apex is not unduly loud, it does not deter us in our decision for operation. We have noted that systolic murmurs of grade I and II intensity will often disappear when the valve leaflets are better mobilized at surgery. At autopsy, we have found that there is always dilatation of the heart with insufficiency if the systolic murmur has been very loud. Particularly when it is accompanied by a systolic thrill, we keep hands off. Similarly, if we find that there is a significantly enlarged left ventricle at fluoroscopy or a left heart hypertrophy pattern signified by the electrocardiogram, then the insufficiency contraindicates commissurotomy.

What about murmurs along the left sternal border due to aortic insufficiency? Our feeling has been that the operation is not contraindicated if this aortic insufficiency is of a mild degree. The width of the pulse pressure of the peripheral circulation has been a reliable guide. If normal, we do not hesitate to go ahead. Some of the decrescendo murmurs have disappeared after operation. This disappearance suggested to us that they were not really due to aortic insufficiency, but Graham-Steel murmurs of pulmonary hypertension.

What if the peripheral pulse pressure indicates an aortic stenosis? At present, this contraindicates operation. We are beginning to do combined operations on the mitral valve and the aortic valve, but it is worthwhile to point out that, when there is a stenotic mitral valve, the real severity of aortic stenosis may not be evident until after the mitral valve is opened when the increased blood flow may accentuate the aortic stenotic murmur. Again, we watch the electrocardiogram and, if there is evidence of a left heart hypertrophy instead of a right heart hypertrophy, we must be cautious about going ahead.

What about the heart rhythm? In patients having atrial fibrillation, we expect the complication of emboli to be somewhat greater, but this arrhythmia alone does not sway our opinion. If, during sinus rhythm, the PR interval on the electrocardiogram is lengthened, an active rheumatic process is suggested unless the patient has taken large amounts of digitalis. Wherever there is recognized active disease, it is our policy to wait until this subsides. The best readily available index for this evaluation is the sedimentation rate.

What then about special studies? In this, we pay especial attention to fluoroscopy. There must be an enlarged left atrium and auricle. Unless these are present, the surgeon will have mechanical difficulty in getting to the valve. On the other hand, if very large, there is almost sure to be some degree of mitral insufficiency. During fluoroscopy, the left atrium will often be seen to expand with systole against the barium-filled esophagus when there is mitral insufficiency. If there is pulmonary congestion and right ventricular hypertrophy with no left ventricular hypertrophy, we have what we consider the ideal candidate. When a calcified mitral valve is seen at fluoroscopy, we alert the surgeon but do not consider that it contraindicates surgery.

The electrocardiogram gives us still more help. May I point out the necessity of taking additional leads in these patients. You know that, in studying coronary disease, we have become used to studying the leads along the precordium on the left side, V_2, V_4, V_5, V_6, ordinarily. In mitral valve disease, we are concerned with the right side of the heart, and it is necessary to take leads on the right side of the precordium. We routinely take V_{4R}, V_{3R} on the right, and V_1. These three leads best delineate right ventricular hypertrophy electrocardiographically when they show a tall upright R wave. Not all suitable patients, however, show this degree of right heart hypertrophy. After the operation there is often a significant change in that the tall R wave over the right precordium disappears.

I have mentioned that we have received some help from cardiac catheterization, but it is in the obscure or unusual case that it really helps clinically. However, our knowledge of the disease has been improved considerably by research studies using the catheter. Peripherally, hypertension can be measured by the sphygmomanometer, but there is no way to measure pulmonary hypertension except during catheterization. A

fair clinical notion is obtained by noting accentuation of the second pulmonic sound. In a general way, the greater the degree of stenosis of the valve, and the greater the disability, the higher the pulmonary arterial pressure. It is possible to apply a formula using data of blood flow and pressures in the pulmonary circuit obtained at catheterization to estimate the size of the mitral orifice. The accuracy of this formula depends on the degree stenosis predominates over insufficiency, which "educated guess" depends more on clinical judgment than catheterization data. We have found that the pulmonary arterial pressure was at least twice normal in every instance that the valve was significantly small to cause disability. Incidentally, nature has providentially allowed a margin for safety in the valve size. The normal opening of 4-6 square centimeters must be reduced to about one and a half square centimeters before symptoms appear. At this size, the pulmonary pressure begins to rise at rest. During the stress of exercise it rises markedly, because the pulmonary vascular resistance has been elevated by congestion and sclerosis, and there is no longer the easy distensibility of the lung circulation, characteristic of the normal person whose pulmonary pressure stays normal with exercise. This partially explains why patients with mitral stenosis are progressively limited in their tolerance for exercise. Clinically, one can predict when the pulmonary hypertension has reached a certain threshold, about twice normal, by the electrocardiogram which will disclose evidence of right heart strain, providing mitral stenosis is the dominant lesions.

At present there is considerable controversy over the benefits obtained by this surgical procedure. From the physiological point of view, the benefit should be measurable in terms of reduction in pulmonary blood pressure and improved output of blood by the heart, particularly with exercise. Our results on 17 patients studied post-operatively showed reduction of significant degree of pulmonary pressure in only about half. Some were markedly lowered, others rose over the pre-operative levels. We were more impressed that almost all of our patients stated they were helped symptomatically. The improved medical care and psychological stimulus of the operation perhaps contributed to this feeling. On the other hand, when the stenosed valve is easily opened at surgery in a patient in whom prolonged failure and cardiac dilatation have not established irreversible changes, the physiological and symptomatic changes are striking.

Surprisingly, we have also obtained good results in some older patients. To date, our oldest patient, aged 53, not only had an uneventful hospital course but has done quite well since his operation. As a matter of fact, in the very young patients, such as those in the second decade and possibly the early third decade, it is likely that active rheumatic carditis may still be present, contraindicating surgery and minimizing the expected favorable result.

In summary, this is a good operation, essentially simple in concept. The major difficulty lies in properly selecting the patients. Only in the obscure case is one of the finer diagnostic measures, such as cardiac catheterization, needed. In general, if we properly examine the patient with ordinary equipment, we can arrive at a decision as to whether or not pulmonary congestion is present, whether the right ventricle and not the left ventricle is under strain from a stenotic orifice and whether opening of the mitral valve surgically will benefit the patient.

What Lies Ahead in The Field of Nutrition

William J. Darby, M.D., Ph.D., Nashville, Tenn.

THE title of my paper indicates that I am a soothsayer and that it is expected that I shall do some crystal gazing. I deny any powers as a mystic, but I shall attempt to extrapolate some of the more recently acquired knowledge in nutrition to the point where it intersects medical practice.

For this purpose, I should like to deal with the topic of nutrition in broad terms and to consider first the advances in understanding deficiency diseases.

Although classical deficiency diseases are not usually regarded as major problems in the United States, within the past two years a new deficiency state has been recognized—namely, pyridoxine deficiency. The syndrome of convulsions in infants which occurred over a wide area appears to have been related to a low dietary intake of pyridoxine or vitamin B_6. Elucidation of this syndrome promises to sort out at least one of the causes of infantile convulsions and to provide a proper understanding of prevention and treatment.

At the same time, through the work of McHenry, McGanity, Vilter, Rinehart, and others, identification of certain biochemical evidences of pyridoxine deficiency in the human has been accomplished. These are alterations in blood urea levels following the administration of amino acid nitrogen and the excretion of xanthurenic acid after load doses of tryptophane. Vilter has produced in adults a clinical syndrome, including oral lesions, seborrheic type of dermatitis, and neuritic symptoms, by the administration of an anti-metabolite of pyridoxine; that is, desoxypyridoxine. The urinary excretion of unusual quantities of xanthurenic acid by pregnant women has been shown to be influenced by pyridoxine. The significance of this finding is as yet undetermined, but it indicates a special group of patients in which investigators should make further studies of pyridoxine metabolism and requirements.

Rinehart and his co-workers observed lesions suggestive of arteriosclerosis in the testes of vitamin B_6-deficient monkeys. Norman Olsen has reported a reversible hypertension in rats which were chronically deficient in pyridoxine. Whether these studies in animals may have significance for disease processes in the human remains to be explored.

Pyridoxine in doses of 150 to 450 mg. per day has been reported to reverse the peripheral neuritis encountered during the course of isoniazid (isonicotinic acid hydrazide) therapy in tuberculosis. Furthermore, doses of 50 mg. of pyridoxine per day prevented the occurrence of this peripheral neuritis during isoniazid therapy. In addition, Vilter has demonstrated that isoniazid enhances the urinary excretion of pyridoxine and has thereby provided laboratory evidence for the induction by this drug of an abnormality of vitamin B_6 metabolism. Aside from the very practical importance of these findings in the maintenance of patients on this useful therapeutic adjunct, they suggest that pyridoxine may be involved in neuritis of other origin.

It requires no crystal gazing, then, to tell us that developments of greatest importance lie ahead in the direction of pyridoxine or vitamin B_6.

The mystery of the interrelationship or interaction between folic acid and vitamin B_{12} remains. Ascorbic acid is important in the metabolism of folic acid, particularly in its conversion to citrovorum factor. This confirmed observation does not, however, clarify all of the interrelationships between vitamin C and folic acid. A clear understanding of the several

---

Professor of Biochemistry and Director of the Division of Nutrition, Vanderbilt University School of Medicine, Nashville, Tennessee.

Presented before the General Assembly, 114th Annual Meeting, Ill. State Medical Society, Chicago, May 18, 1954.

anemias which are controlled in whole or in part by these three factors can be arrived at only through future work. It is probable that the mechanism of these interrelationships will be elucidated by basic studies in animals and in the biochemical laboratory, and that the understanding of the mechanisms may influence greatly our diagnosis and therapy of anemias.

Progress is being made toward the isolation and identification of the intrinsic factor. This factor, as you know, is the gastric substance which is necessary for the absorption of vitamin B_{12}. It is absent or greatly decreased in quantity in patients with pernicious anemia. Although it may be that the availability of a highly active and dependable preparation of intrinsic factor may allow for the successful management of patients with pernicious anemia through therapy by the oral route, any such development is still in the future. It will require five or more years of critical testing of such a treatment-method before one can confidently recommend it as a replacement for present satisfactory maintenance.

Much interest exists in the possible influence of intrinsic factor upon gastrointestinal absorption of nutrients other than vitamin B_{12}. From knowledge of this function in the patient with pernicious anemia, one may predict that this factor will have no wide spectrum of influence upon absorption.

The laboratory nutritionist recognizes a number of factors which are essential for various species and which have not yet a defined place in human nutrition or metabolism—to mention but a few, pantothenic acid, the tocopherols, biotin, thioctic acid. Just as the past decade has placed folic acid, vitamin B_{12}, and pyridoxine in the category of useful therapeutic agents, it will be most surprising if some of these others do not find a way into recognized places in medicine during the next decade.

But deficiency diseases are not our most important problem: Degenerative diseases cause many more deaths in the United States than do deficiencies. We have made but a beginning on understanding the role of nutrition in relation to the former. I have already mentioned the two intriguing findings on pyridoxine in relation to experimental hypertension and arteriosclerosis. This audience knows well the recognized relationships between obesity or caloric excess and hypertension, diabetes, cancer, and the like. Studies under way in Keys' laboratory in Minnesota and elsewhere will provide better methods of determining body composition and, hence, allow for improved understanding of obesity. Investigations upon the details of the metabolism of obese animals and of the chemistry of appetite regulation should give leads which will make more effective our efforts to prevent and cure this syndrome.

At present one cannot make a clear picture of the metabolism of cholesterol, its relationship to atherosclerosis, to dietary intake of fat or of cholesterol, the nutriture as to ascorbic acid, pantothenic acid, and so on. Several points seem established. Cholesterol is synthesized in the animal body. The cholesterol content of the blood is often increased in atherosclerosis. Blood cholesterol can be influenced slightly by drastic changes in cholesterol intake. But none of these points provide us the basis for convincing, well-founded therapeutic regimens.

It is evident that the concentration of cholesterol in the serum may vary under physiologic stimuli (as exemplified by the increase during pregnancy) or under pathologic stimuli, despite rigid restriction of cholesterol in the diet. This latter may be illustrated by studies in our laboratories of the serum cholesterol values on rats maintained on essentially a cholesterol-free diet, but fed on increasing quantities of sodium chloride. At the higher levels of dietary sodium chloride there occurs a striking increase in blood pressure of the rat — which increase in blood pressure is associated with a rise in serum cholesterol. I do not have time to go into the details of these studies or of their many ramifications. However, taken together with our present knowledge of the ofttimes usefulness of sodium restriction in the treatment of hypertension, these observations have caused us to begin an investigation of the sodium choloride intake of individuals on self-chosen dietaries and the possible relationship to hypertension.

Indeed, it may be that the interrelationship between dietary sodium and potassium is far more important than has been considered in recent times. Dr. Paul Cannon of the University of Chicago has demonstrated that the reduction

of dietary sodium to very low levels may prevent microscopic changes associated with experimental potassium deficiency in rats. Investigations which are under way on sodium and potassium should indicate whether studies of their interrelationship might profitably be extended to patients with hypertension. From such investigations there may come modification of our ideas of the importance of these commonest of inorganic nutrients.

Reports of sound, active explorations of certain trace minerals, especially copper and zinc, are appearing. The evidence indicates that variations in these substances and their protein-linked compounds in the human are primarily a result of disease or physiologic changes rather than of dietary deficiencies. Nevertheless, elucidation of their metabolism may well provide us in the future with potent therapeutic approaches to difficult disease problems.

As I have warned elsewhere, however, it is essential that we be coldly factual in our considerations of these nutritional factors in health and disease and that we base our claims upon positive knowledge rather than upon the fears and superstitions of ignorance. This is especially true of the trace elements because excesses of these are known to be toxic. Furthermore, these elements seem "somehow to light the hopeful imagination of the public and thereby to ignite the flame of all-consuming and often mythical fires of deficiency diseases."

Of those trace elements concerning which there are more claims than knowledge are molybdenum and cobalt. Any therapeutic usefulness which these are claimed to have is purely emperical and most likely pharmacologic, if, indeed, real. While future studies may reveal a deficiency syndrome in the human which results from lack of these elements, no such evidence has yet been presented.

The trace element, iodine, on the other hand, is an entirely different situation. The usefulness of iodine in combating endemic goiter is a story so familiar as to need no repetition. It is so familiar that it will probably be a surprise to know that iodine deficiency goiter is held to be the commonest dietary deficiency in the world. Prevalent is endemic goiter in the mountainous portions of many regions—Central America, South America, India, Yugoslavia, and Austria, to name but a few. Effective iodinization of salt in these areas has been hampered by the problem of the stability of iodine in crude, moist salt which is used by such a large portion of the peoples of the world. Just within the past two years, a pilot study at the Institute of Nutrition for Central America and Panama has demonstrated that iodate is stable in this crude salt and is active in the prevention of goiter. Co-ordinated studies of this preventive measure were undertaken largely through the influence of the World Health Organization. If the initial promise of this method holds, we may see a new hope for the eradication of a deficiency disease now widely prevalent in the world.

A similar example of an attack on a widespread deficiency disease is the recent studies of methods to control pellagra which have been instituted by the World Health Organization and by funds made available by the Williams-Waterman Fund of New York City. Pellagra still exists in areas where the major article of diet is maize; for example, in Yugoslavia and Egypt. One method of control which is under test is the enrichment of maize at the time of grinding. This consists of the addition of nicotinic acid, riboflavin, and other nutrients in the form of a mixture at the time of milling. Other methods of applying nutritional knowledge to the solution of this disease problem are being used as well.

I would not predict the time necessary to make extensive inroads into the vast problem of deficiency diseases outside of the United States. I am, however, optimistic that real beginnings have been made in an effort to apply modern nutritional knowledge to the control of disease throughout the world.

But what of diet therapy in every day practice—in the management of the surgical patient, of the man with gout, of the pregnant or lactating woman?

Accumulating knowledge of nutrition and metabolism, of food values and their practical usefulness, and of the patient-acceptance of foods is bringing us from the era of emperical dietetics to that of diet therapy based upon sound knowledge and understanding.

Today, before we recommend a dietary regimen, we consider the evidence that an en-

hanced synthesis of uric acid occurs in gout and that this may be altered by properly constructed diet. We reflect on the altered physiology occasioned by gastrectomy in order to provide protection against macrocytic anemia through provision of vitamin B_{12} (or, perhaps at some future time, intrinsic factor). We recognize that supplementary iron as preventive therapy for the pregnant woman is effective during the last half of pregnancy and in the post-partum period—not during early pregnancy. We realize that the lactational months are greater nutritional drains upon the maternal organism than are the nine months of gestation. Above all, we recognize that a therapeutic diet is but a modification or a control of quantity of a normal dietary and, if it is not nutritionally adequate, any long-term adherence to it will be injurious to the patient.

If I were to answer the question "What lies ahead in diet therapy?" I would reply: "A healthier patient and world population because of the advice of a more enlightened medical profession."

‹‹‹ ›››

The executive

As every body knows, an executive has practically nothing to do except to:

1. Decide what is to be done;
2. Tell somebody to do it;
3. Listen to reasons why it should not be done, why it should be done by someone else, or why it should be done in a different way;
4. Follow up to see whether it has been done;
5. Discover that it has not been done;
6. Inquire as to why;
7. Listen to excuses from the person who should have done it;
8. Follow up again to see whether the thing has been done, only to discover that it has been done incorrectly;
9. Point out how it should have been done;
10. Conclude that as long as it has been done, it may well be left where it is;
11. Wonder whether it is not time to get rid of a person who cannot do a thing right; to reflect that he probably has a wife and a large family and that certainly his successor would be just as bad and maybe worse.
12. Consider how much simpler and better the thing would have been done if one had done it onesself in the first place;
13. Sadly reflect that one could have done it right in 20 minutes and, as things turned out, one has to spend two days to find out why it has taken three weeks for somebody else to do it wrong. *Ossining Rotary Club. New York J. Med. Jan.* 15, 1954.

COOK COUNTY HOSPITAL CASE RECORDS



One Hundred Consecutive Appendiceal Masses in Children

Frank Milloy, Jr., M.D. and Egbert H. Fell, M.D., Chicago

THE significance of a palpable abdominal mass in the course of an episode of appendicitis is still controversial. Whereas Richardson[12] in 1894 expressed the thought that there was a time too late for an early operation and too early for a late operation, most American surgeons in the years immediately following Fitz's epochal paper[3] felt that immediate surgery was usually indicated.

Deaver[2] in 1896 stated that all inflamed appendices should be removed and Price[6] in 1905 in a review of 1900 cases stated that localized abscess was an erroneous term and that no dependence should be placed on an inflammatory wall as an aid in preventing the spread of peritonitis. It was Ochsner[10] in 1902 who crystallized thought on the conservative treatment of appendicitis. His primary contraindication to surgery, however, was an incompetent surgeon and he did not emphasize the importance of a time interval or a palpable abdominal mass. He was, however, impressed by a statement by Myntner[9] that of 20 patients he had operated with perforation and peritonitis, all fifteen operated after the third day died.

In 1942 Guerry and McCutchen[5] stated that surgery should be deferred in that group of patients first seen with diffuse peritonitis but that appendectomy should be performed when a localized abscess had formed, usually after a period of a few days. Chenoweth[1] in 1943 reviewed 3,600 appendectomies in a ten year period at the New York Hospital in which 149 patients were found to have appendiceal abscesses. He felt that this condition was an indication for surgery and that the appendix should be removed if not too difficult technically. This was possible in 60 per cent of patients in his series.

Potts[11] in 1938 reported a series of 105 children with appendiceal mass. Seventy-three were treated surgically with a 5.4 per cent mortality and 32 were treated conservatively with no mortality. In his cases, where doubt occurred in the first two or three days of the disease as to the presence of a mass, the child was anesthetized and the abdomen again palpated. If a mass was then felt, no surgery was performed. Rogers and Faxon[13] in their comprehensive review of appendiceal peritonitis in the period from 1929 to 1940 at the Massachusetts General Hospital stated that in an episode of appendicitis the formation of a palpable mass is the most fundamental of the preoperative clinical findings. They also said that this event was "indisputable evidence of some degree of localization and hence, at least from the point of view of treatment, serves to separate the group in which localization has already occurred from the group in which

From the Cook County Children's Hospital, Chicago, Illinois.

localization has not and perhaps will not take place." Of 222 patients with a mass 47 per cent had a primary appendectomy and the remainder had incision and drainage of the mass. The latter group was made up largely of patients with longer histories. In the 46 patients of their series subjected to appendectomy on the fifth, sixth or seventh days of illness, there was a 20 per cent mortality. They frequently postponed surgery for several days in the belief that the local process would progress to a stage more favorable to surgery. They did not believe that any of these undrained abscesses spontaneously ruptured into the general peritoneal space. They also felt that it must be extremely rare in an unoperated case for a localized mass secondary to a ruptured appendix to subside completely without spontaneous drainage, operation or death. At this hospital, Meyer, Requarth and Kozoll[7] reported that in the years 1944 and 1945 there was an 8.5 per cent mortality in treating patients with appendiceal abscess surgically (appendectomy and/or drainage) and a 3.1 per cent mortality for those treated conservatively.

In the recent edition of his book Gross[4] states that palpable mass is an indication for surgery and that the appendix can be removed 98 per cent of the time.

OBSERVATIONS

From January 1946 to April 1954 the diagnosis of appendiceal mass was made 100 times on the pediatric surgery ward of the Cook County Hospital. These children were under 14 years of age, less than five feet tall and in the case of girls, had not reached the menarche. The total surgical admissions to the ward during this period numbered 23,098. Six hundred and ten appendectomies were performed.

The patients with appendiceal masses were divided into two groups according to the method of treatment. The first group was made up of children in whom an appendiceal mass was palpated and who were not treated with early appendectomy. The second group was made up of children treated with appendectomy in whom the surgeon encountered a definite appendiceal abscess with walled off pus. Thus there were two ways of diagnosing appendiceal mass — by physical examination and by actual observation of an abscess at surgery.

PATIENTS TREATED CONSERVATIVELY

There were 83 patients in the first group, those treated conservatively. The diagnosis was made in patients with a history compatible with appendicitis in whom an inflammatory mass was palpable in the lower abdomen or by rectum on admission or at some time during the course of their illness. The mass was palpable abdominally in 44 patients, rectally in 13 patients and both abdominally and rectally in 26 patients. In four cases the mass was in the midline or on the left.

Although the mass was usually palpable by routine physical examination, in twelve patients special methods of relaxation were required. In nine instances the mass was palpated in the operating room after the child had been anesthetized and prepared for surgery. These children were then returned to their rooms without operation. In two instances where examiners were highly suspicious of a mass the patients were anesthetized with vinyl ether on the ward and the diagnosis made, and in one child the mass could be palpated after administration of morphine sulfate grains 1/12.

Of the 83 patients treated conservatively 74 had a palpable mass on admission to the hospital and in nine patients the mass appeared later. In three instances the mass appeared during an episode of measles and once during an episode of mumps. In three instances the mass developed while the patient was under observation for extremely mild abdominal symptoms, being worked up for intestinal parasites et cetera. A mass developed in two children admitted with severe peritonitis, which gradually subsided with treatment by the Ochsner regimen, leaving a localized right lower quadrant process.

The treatment of this group varied with the severity of the attack and with the therapeutic agents in use at the time. Seventy-nine of the 83 patients treated conservatively received penicillin, 44 streptomycin and 7 one of the broad spectrum antibiotics. Sixty-eight required intravenous fluids and forty-two required intestinal decompression. Twenty-four were given blood transfusions and one patient was ill enough on admission to require oxygen.

Seventy-three of these appendiceal masses subsided without surgery and without demonstrable spontaneous drainage. Eight of the pa-

tients required abdominal incision for drainage of an abscess and two were presumed to have drained spontaneously when frank pus was found in the diaper associated with the patient's clinical improvement. Surgical drainage was delayed to give the abscess time to become well localized and to rule out the possibility that it would subside spontaneously. In the eight cases drained, the time of surgery varied from the tenth to the thirty-fourth day of illness. Two of the masses which were drained were on the left side. At the time of surgery free pus was encountered in all but one patient. In this case the mass was made up of a phlegmon of small bowel and omentum with a fibrinous peritonitis. This patient probably would have benefited by a longer period of observation. Although one child was suspected of having a subphrenic abscess in the course of her illness, this complication was not encountered in this study.

In seven of these 83 patients the appendiceal mass was a complication of measles, mumps or chicken pox. Three of the patients had abdominal masses at the time of admission and four developed masses while being treated for the contagious disease. In fairness it must be said that many appendectomies were performed in the contagious hospital during the eight years covered by this study, and the difficulty in distinguishing the symptoms of appendicitis from those of the contagious diseases are illustrated in the following case.

Case 1. — A. P. This six year old white female was admitted to Cook County Hospital at 3:00 p.m. on February 11, 1947 with an admitting room diagnosis of mumps with mumps pancreatitis. She complained of left parotid swelling for four days and periumbilical pain, vomiting and diarrhea of one day's duration. One sibling at home had mumps. Past history negative. Temperature 103° (rectal); pulse 104; respirations 36. There was tender swelling of the left side of the face. There was generalized abdominal tenderness, maximal in the periumbilical region with rigidity over the entire abdomen. Bowel sounds were hyperactive. Rectal examination revealed tenderness, more marked on the right. The urine was negative, the white blood count was 13,600 and there were 86% polymorphonuclear leucocytes. The serum amylase was 16 units in a test where normal ranges from 8 to 32 units. The impression was mumps with associated pancreatitis or oophoritis. She was treated with intestinal decompression, fluids, penicillin and whole blood. During the first four hospital days the child showed little change of the abdominal findings, however, her temperature dropped to 101°. Two repeat serium amylase determinations were 32 units and 16 units, and a repeat white blood count was 13,000. The Kahn was negative and the red blood count was 4,120,000. On the fifth hospital day the findings were localized to the lower abdomen; she gradually improved, and on the thirteenth hospital day a golf ball sized mass was palpable in the right lower quadrant. The mass gradually subsided and the child was discharged.

Of these 83 patients, eight returned after resolution of the mass and discharge with recurrent attacks. All were advised to return in three months for an interval appendectomy; however the records show that only 27 did so.

PATIENTS TREATED BY EARLY APPENDECTOMY

There were 17 patients in the second group — those in whom the diagnosis was made or confirmed at the time of appendectomy. The general policy at the hospital during the period of this study has been to treat appendiceal masses conservatively. However, in five instances because of variations in individual judgment appendectomy was performed in the presence of a papable appendiceal mass. In 9 patients the diagnosis was simple appendicitis or appendicitis with peritonitis and an appendiceal abscess was found at surgery. There were 3 cases in this group in which an appendiceal abscess caused a mechanical small bowel obstruction. This condition is illustrated by the following case history.

Case 2. — H. S. This 15 month old negro male was admitted to Cook County Hospital at 4:15 p.m. on September 4, 1953 with an admitting room diagnosis of gastroenteritis. He had been well until two weeks previously at which time he developed a "cold" and loss of appetite. Four days before admission he developed diarrhea with eight stools daily which lasted until the morning of the day before admission, and since then his bowel had not

moved. For two days before admission he complained of abdominal pain, he vomited everything he ate and his abdomen began to distend. The past history was negative, there were seven siblings at home, all of whom had diarrhea during the previous two weeks. Temperature was 103.20 (rectal) and pulse was 110. The pharynx was mildly injected. The abdomen was distended, measuring 19½ inches and tympanitic. Bowel sounds were absent. There were no palpable masses, organs or rigidity and little or no tenderness. There was no scar. Rectal revealed no masses, no tenderness and no stool. The urine was negative, and hemoglobin was 80 per cent. A flat plate of the abdomen revealed distended loops of small bowel. A barium enema revealed no distention or obstruction of the colon. Treatment consisted of intestinal decompression, intravenous fluids, penicillin, streptomycin and 125 c.c. of whole blood. On the morning after admission the temperature was 100.40, the child had passed no stool, the abdomen measured 18¼ inches and infrequent bowel sounds were heard. The N. P. N., chlorides, sodium, potassium and carbon dioxide combining power were within normal limits. By the evening of the day after admission the child had still passed no stool, infrequent peristaltic rushes were heard and the abdomen was becoming tender. He was taken to surgery with the diagnosis of mechanical bowel obstruction. The abdomen was entered through a rectus cutting lower abdominal transverse incision under ½ per cent procain infiltration. A perforated suppurative appendix was found lying behind the terminal ileum and mesentery in an abscess causing a kink in the ileum which was resulting in a mechanical obstruction. The appendix was removed, the child made an uneventful recovery and was discharged ten days post-operatively.

The second of these three cases was that of a four year old colored male with a two week history of abdominal pain, constipation and vomiting. The abdomen was distended, bowel sounds were hyperactive and there was a left lower quadrant mass. The flat plate was suggestive of a mechanical bowel obstruction. The child was explored through a paramedian incision as a possible intussusception and an appendiceal abscess causing a mechanical small bowel obstruction was found. The third case was similar.

The patients in the second group all received an antibiotic, intravenous fluids and intestinal decompression. Eight of the seventeen required blood transfusions. One of the patients had developed appendicitis as a complication of measles.

Of the 100 children in this series, 13 were less than three years old, 60 were between three and nine and 27 were over nine. The youngest was admitted at the age of four months with a nine day history and an abscess which was drained abdominally on the thirty-fourth day of her illness. An interval appendectomy six months later revealed a residual abscess.

There were 54 boys and 46 girls. The duration of symptoms of these patients on admission is given in Table I and the weeks hospital stay in Table II. There were no deaths in this series of 100 appendiceal abscesses.

Appendicitis resulted in death in eight chil-

TABLE 1
THE DURATION OF SYMPTOMS OF THE PATIENTS ON ADMISSION

Days Duration of Symptoms on Adm.	Treated Conservatively	Early Appendectomy	Total
1	5	2	7
2	7	3	10
3	5	6	11
4	12	1	13
5	16		16
6	12	1	13
7	6		6
8	3		3
9	3	2	5
10	4		4
11 or over	10	2	12

TABLE 2
WEEKS HOSPITAL STAY

Weeks Hospital Stay*	Treated Conservatively	Early Appendectomy	Total
1 or less	8		8
2	24	4	28
3	20	8	28
4	13	3	16
5	8	1	9
6	4	1	5
7			
8	2		2
9	3		3
11	1		1

*Fractions counted as additional weeks

dren at the hospital during the period of this study. Four of these patients had similar courses. They had three or four day histories, were extremely ill or preterminal on admission and underwent appendectomy after institution of appropriate conservative measures. Appendicitis with no walling off and diffuse peritonitis were found in each case and all died within 24 hours of admission. A fifth child with a five day history was terminal on admission and a similar diagnosis was made at postmortem. Two children who were less seriously ill at the time of admission died, one during surgery, evidently due to a complication of anesthesia, and one on the eleventh post-operative day after having developed subphrenic and lung abscesses. The eighth death was in a 29 day old infant who had been admitted at the age of nine days and treated on a medical ward as a bacteremia, in whom the diagnosis of suppurative appendicitis was made at postmortem. None of these eight patients had a mass on physical examination and none had evidence of walling off at surgery or postmortem.

DISCUSSION

Whereas wider public education has made earlier diagnosis and treatment of appendicitis possible and thus saved many lives, there is one age group that does not seem to have benefited from this factor. The Vital Statistics of the United States of America reveal that although there were 70 per cent less deaths from appendicitis in 1948 than in 1930 in the age group from three to fourteen years, in children below the age of two the death rate was the same in these two years.

Acute inflammation of the appendix is usually an obstructive phenomenon[14]. If this does not subside spontaneously by such means as expulsion of the fecalith, or if the appendix is not removed surgically, there may be two ultimate results. As the appendix becomes more acutely inflamed and bursts, the small bowel and omentum tend to form an inflammatory wall around it. If this wall is sufficiently strong, as it most commonly is, the process will remain localized as a mass. The term appendiceal mass as it is used here includes two stages of severity of the pathology. The less severe local reaction to an inflamed appendix is a phlegmon of edematous omentum and bowel, sealed around the organ by a fibrinous peritonitis. The difference between this process and an appendiceal abscess is the presence of free pus within the inflammatory wall. If the inflammatory wall is not sufficiently strong, and localization does not take place, the fecal material will spill into the general peritoneal cavity and cause a spreading peritonitis[8]. Myntner[9] in 1894 said that 20 per cent of patients developing acute appendicitis die if not operated.

The clinical significance of the two types of mass, the phlegmon and the abscess, is that the phlegmon, which is more common, will usually subside with conservative treatment, while an abscess may enlarge, produce increasing signs of general sepsis and require drainage.

In this series the diagnosis of appendiceal mass was based on the actual palpation of the mass and was never presumed on the basis of time interval. Two of the children were operated in the ninth day of their illness, in neither of whom could a mass be palpated. As may be seen in Table 1, twelve of the children admitted on the first two days of their illness were treated conservatively. This reflects the difficulty in obtaining accurate histories in the case of many young children. Also included in these twelve were those patients in whom a mass developed during the hospital stay.

Table 2 should not be used as a comparison of the two methods of treatment. Although the patients treated by early appendectomy had shorter hospital stays, they were a selected group. As a rule they were not as sick as those treated conservatively and had much smaller masses.

Although only 27 of the 83 patients treated conservatively were returned by their parents for interval appendectomy, this figure would probably be higher in a more responsible social stratum. Some may also have been taken to other hospitals for surgery.

CONCLUSIONS

Acute inflammation of the appendix may subside spontaneously or may proceed to perforation.

Acute perforated appendicitis may terminate in either a localized inflammatory mass or a generalized peritonitis.

The occurrence of a palpable mass during an episode of appendicitis is of major importance.

This is indisputable evidence of a degree of localization of the inflammatory process.

The ultimate treatment for an appendix which has once become inflamed is removal. The treatment for early appendicitis and for appendicitis with spreading peritonitis is appendectomy.

When the protective mechanisms of the peritoneal cavity have sufficiently walled off an inflamed appendix to make a mass palpable, the infection should be treated by conservative measures, including drainage of the abscess when necessary.

Interval appendectomy should be performed in from three to six months.

SUMMARY

In a period of eight years and three months during which 610 appendectomies were performed on children at the Cook County Hospital, the diagnosis of appendiceal mass was made 100 times — either by physical examination or at surgery.

Eight of these developed as a complication of one of the contagious diseases.

Eighty-three of these children, each of whom had a palpable mass, were treated conservatively and advised to return for interval appendectomy. Eight of these abdominal masses required drainage by abdominal incision and two drained spontaneously per rectum. The remainder subsided without drainage.

Seventeen of the children, most of whom did not have a palpable mass, were treated by early appendectomy. In three cases an appendiceal abscess caused a mechanical bowel obstruction by kinking the terminal ileum.

There were no deaths in these one hundred children with localized masses. However, there were eight deaths in children with appendicitis during the period of this study.

BIBLIOGRAPHY

1. Chenoweth, A. I.: Appendiceal Abscess. Surgery, **14**:702, 1943.
2. Deaver, J. B.: A Treatise on Appendicitis. Philadelphia, P. Blakiston & Son, 1896. P. 116.
3. Fitz, R.: Perforating Inflammation of the Vermiform Appendix. Tr. Assn. of Am. Physicians; 1:107, 1886.
4. Gross, R. E.: The Surgery of Infancy and Childhood. Philadelphia, W. B. Saunders Co., 1953.
5. Guerry, L. and G. T. McCutchen: The Management of Appendiceal Peritonitis with Special Reference to the Operative Handling of the Localized Abscess. Ann. Surg., **115**:228, 1942.
6. Kennedy, J. W.: Appendicitis: The Earliest and Complete Removal of the Appendix. Surg., Gynec. & Obst., **1**:216, 1905.
7. Meyer, K. A., W. H. Requarth and D. Kozoll: Progress in the Treatment of Acute Appendicitis. Am. J. Surg., **72**:830, 1946.
8. Miller, E. M., E. H. Fell, C. Brock and M. C. Todd: Acute Appendicitis in Children. J.A.M.A., **115**:1239, 1940.
9. Myntner, H.: Appendicitis and Its Surgical Treatment. Philadelphia, J. B. Lippincott Co., 1897. P. 122.
10. Ochsner, A. J.: A Handbook of Appendicitis. Chicago, G. P. Engelhard & Co. 1902.
11. Potts, W. J.: Acute Appendicitis in Children. Am. J. Dis. Child., **55**:511, 1938.
12. Richardson, M. H.: Remarks upon Appendicitis Based Upon a Personal Experience of One Hundred and Eighty-One Cases. Am. J. M. Sc., **107**:1, January, 1894.
13. Rogers, H. and H. Faxon: A Statistical Study of Six Hundred and Seventy-One Cases of Appendiceal Peritonitis. New England J. Med., **226**:707, 1942.
14. Wangensteen, O. H. and C. Dennis: Experimental Proof of the Obstructive Origin of Appendicitis in Man. Ann. Surg. **110**:629, 1939.

‹‹‹ ›››

Operate early

Since we rarely make the diagnosis of cancer of the stomach before it has progressed beyond the stage of resection with expectation of cure in most instances, and since even when a lesion is demonstrated we cannot speak with finality regarding the malignant or benign nature of the lesion, is it not the obligation of this profession not only to offer but to urge early operation upon these patients and not to invite possible disaster by subjecting them to prolonged medical treatment? It is only by adopting an uncompromising attitude that we can hope to increase our salvage rate in this dreadful disease. *Calvin M. Smyth, M.D. Gastric Cancer. Pennsylvania M.J. Feb.* 1955.

EDITORIALS

Diagnosis of benign gastric ulcer

Do benign gastric ulcers always undergo malignant degeneration? There is growing evidence that they do not. Every attempt should be made, therefore, to differentiate innocent and harmful lesions so that sound treatment can be recommended. This often is possible through careful clinical evaluation and utilizing all the diagnostic aids available.

The history is of little value because the pain-food-relief sequence may occur in both types of lesions. Weight loss, anorexia, hematemesis, and anemia point to malignancy but do not offer conclusive evidence. Age is not a factor. A long duration or frequent recurrences suggests a benign gastric ulcer.

The laboratory is most helpful. Benign lesions rarely exist in the presence of a proved histaminic achlorhydria. The absence of blood in the stools following a meat free diet or on adequate ulcer therapy seldom occurs when malignancy is responsible.

Gastroscopy is most important in diagnosis and follow-up surveys. But, to make an honest appraisal, the gastroscopist must be able to visualize the entire circumference. The best view is obtained when the ulcer lies above the angle of the stomach along the lesser curvature. The prepyloric area and the posterior wall cannot be visualized. Benign lesions have sharp, clean cut margins between the ulcer floor and the surrounding orange-red mucosa. There is no infiltration and the ulcer wall slopes gradually into the whitish ulcer floor.

X-ray is valuable but has its limitations in differentiating the two conditions. In one survey, the roentgenologist was able to make the correct diagnosis in one-third of the cases and a suggestive diagnosis in an additional one-third. The location of the lesion helps; ulcers above the lesser curvature are benign in 90 per cent of all cases.

Size is no criterion but peristaltic activity, contour of the crater, the presence of a meniscus sign, and pliability of the surrounding wall are important signs. Radiation of the folds also plays an important role in evaluation; in benign lesions the folds usually are parallel and seldom end abruptly in the lesion.

Exfoliative cytology is becoming more popular in diagnosis. The papain and Ayre brush methods are the usual procedures.

If malignancy cannot be ruled out, surgery is recommended. It is necessary also when the lesion does not heal within a reasonable time and the acid content is high.

‹ ›

Proposed Maternal Welfare Committee for Illinois

Maternal welfare in the state of Illinois is receiving much more attention than in most of the other states. This is because the Illinois State Medical Society, the Illinois State Department of Public Health and the Health Department of the City of Chicago took an active interest in the creation of safeguards for maternity care. During the years since 1934 when the American Committee on Maternal Welfare began to function there has been a consistent drop in the mortality figures from 7 per ten thousand to .3 per ten thousand. So it is evident that, among other factors, a well thought out program for the protec-

tion of mother and their newborn babies has an important place in our defense against these dangers.

We believe that a further step in this direction would be the formation of an Illinois Committee on Maternal Welfare composed of representatives from the obstetrical specialty societies, the general practitioner, the nursing profession, the Illinois State Department of Public Health, the Chicago Health Department and the medical colleges, both state and private institutions.

With this as a nucleus there could be developed a comprehensive plan in which duplication of effort could be minimized and the maximum of efficiency attained. Cooperation between this chapter and the patient committee on maternal welfare together with liaison with other similar state chapters would produce one of the most powerful organizations for maternal welfare ever developed.

Illinois is taking the lead in this program and we ask the support and cooperation of members of all of these organizations to assist us in the develpment of this plan. It should have a powerful and favorable effect on our public relations.

‹ ›

Kendall County Medical Society reorganized

On the evening of April 27, 1955, the officers of the Illinois State Medical Society met with a group of physicians and guests in the Masonic Temple at Yorkville to present the charter to the reorganized Kendall County Medical Society. There were 29 assembled for the dinner and the program which followed. The President of the society, Dr. L. A. Perkins introduced Dr. Edwin S. Hamilton of Kankakee, Councilor for the 11th Councilor District in which Kendall County is located.

Dr. Hamilton told the group that it was a distinct pleasure for himself as Councilor to meet with them on this unusual occasion, as a charter had not been issued to a county medical society during the past forty years or more. He assured them of his desire to cooperate in every way possible as their Councilor representative in the State Society. He then introduced Dr. Arkell M. Vaughn, President of the State Medical Society.

Dr. Vaughn also told of his interest in this



Left to Right: Walter Brill, Jr. Secretary of the New Society, Arkell M. Vaughn, Joseph O'Neill, Harold M. Camp, L. A. Perkins, President of the New Society, Edwin S. Hamilton, Councilor.



Pictured Above, Left to Right: Back Row: M. R. Saxon, Oswego, Roy Crawford, Plano, Victor Smith, Newark, Harold C. Wright, Yorkville. Front Row: L. A. Wunsch, Yorkville, Lyman Perkins, Yorkville, Walter J. Brill, Jr., Oswego.



Pictured above, Left to Right: Back Row: Mrs. Roy Crawford, Plano, Mrs. Harold C. Wright, Yorkville, Mrs. Victor Smith, Newark, Mrs. M. R. Saxon, Oswego. Front Row: Mrs. L. A. Wunsch, Yorkville, Mrs. Walter Brill, Jr., Oswego, Mrs. Carlson (Daughter of Dr. Perkins) Yorkville.

meeting. He had cancelled an appointment at another meeting that evening where he was supposed to participate in the program. He gave his assurance that the Illinois State Medical Society was pleased to have a county society again operating in Kendall County and said it was unusual that the President of the State Society was permitted to participate in a meeting of this kind.

Dr. Joseph T. O'Neill, Chairman of the State Society Council, then officially made the presentation of the framed charter to the officers of the new Society. Both he and the State Society Secretary told of the original Kendall County Society chartered originally in January, 1902.

Dr. Camp then referred to an older Society operating in Kendall County more than 75 years ago, and also told of some of the pioneer physicians of the county dating back more than 100 years. Records in his possession show that delegates from the county were seated at the annual meetings, in the early 1870's. The officers of the Kendall County Medical Society who had been previously elected, were

Dr. L. A. Perkins, Yorkville, President.

Dr. Walter H. Brill Jr., Oswego, Secretary-Treasurer.

The Delegate elected for the State Society House of Delegates was Dr. M. R. Saxon, Oswego.

This added one society to the list of component societies of the Illinois State Medical Society, making the total 93. As is generally known, there are several joint county societies composed of members from two adjoining counties, and at this time physicians in every county in Illinois hold membership in their State Society.

‹ ›

James C. Leary

The thousands of friends of James C. Leary were shocked to hear of his sudden death while attending a meeting of the Council of the Chicago Medical Society on Tuesday evening, April 12. Jim began his work for the Illinois State Medical Society in 1945 as a member of Salter and Associates, a firm of public relations advisors. Two years later he became the public relations director for the State Society, and worked diligently in that capacity until his untimely death.

Last September he had a severe coronary attack for which he was hospitalized for a number of weeks. Then he remained at home for several weeks before being permitted to return to his office for short hours every other day. He had gradually been increasing his activities, and was always anxious to be of service to this Society, as well as to the Chicago Medical Society. He attended the meetings of the C. M. S. Council as well as the meetings of the I. S. M. S. Council.

Before coming to work as public relations director, he had been science editor for the Chicago Daily News for a number of years. He was a war correspondent in the South Pacific area during World War II, and wrote many articles on the methods of handling service men wounded in battle.

Jim was a native of Connecticut, and had worked on newspapers in the east before coming to Chicago. He was intensely interested in medical public relations and developed many articles and published several brochures on that subject, many of which received wide distribution throughout the country. He spoke before many county medical societies in Illinois, and had frequent meetings with society officers and public relations committees to discuss this favorite subject with them.

For the past two years he was responsible for the public relations page in the Illinois Medical Journal, which was an increasingly popular venture.

He was a former president of the National Association of Science Writers, and a civilian consultant to the Surgeon General of the Army.

During the annual meetings of this Society for the past ten years, he had been in charge of the press room, and had released many hundreds of stories for the papers. He encouraged many science writers and assisted in preparing releases dealing with outstanding achievements in medical care as presented in the papers given before members of this Society.

Mr. Leary is survived by his widow, Marjorie; three brothers, Edward, Francis and Cornelius, Jr., and by one sister, Margaret, and by his aged father, Cornelius P. Leary.

Nearly every member of the Illinois State

Medical Society knew Jim Leary, and always respected his keen judgment in his daily relations with his patients. We all remember the basic principles of good public relations that Jim always discussed with us. His many friends in Illinois and throughout the nation will join in their expression of sympathy to Mrs. Leary and other members of his family.

‹ ›

A. M. A. plans new type health exhibits

The American Medical Association Bureau of Exhibits is planning a new type of exhibits to acquaint people with their bodies and the size and location of various organs, to depict the basic anatomy of the human body. Each exhibit will feature life size, three dimension models of particular parts of the body and should prove invaluable as a health education aid.

Typical of this new group of exhibits in "Life Begins" which tells the story of the beginning of life. Actual human fetuses embedded in plastic will trace the growth of a baby from four weeks to nine months. There will also be a three dimension, life size model of the female pelvis and diagrams showing the uniting of the sperm and the ovum, the division of cells, and the travel of the fertilized ovum into the uterus. The final section of the exhibit will portray in life size the actual delivery of a baby.

We are informed that this exhibit will be available about September 15. Other exhibits in the series, scheduled for release next year, will be on vision and hearing. Tentative titles selected for these exhibits are "We See" and "We Hear".

The American Medical Association is to be congratulated for the development of these fine exhibits, and we are informed that the first of the series entitled "You and Your Body" is currently available.

‹‹‹ ›››

Gastroscopy

Gastroscopy is considered to be an important adjunct to other methods of examination, complementary and supplementary to radiologic examination and not in any way a rival procedure. As a single means of examination, radiology undoubtedly is superior. However, the demonstration of a gastric lesion by the radiologist should usually imply confirmation by the gastroscopist. Lesions high up on the greater curvature are frequently difficult to palpate and study radiologically, but are usually well seen with the gastroscope; on the other hand, small lesions close to the pylorus, on the lesser curvature of the antrum, high on the lesser curvature of the body, and high in the fundus are much better seen by the radiologist. If the X-ray findings are doubtful, gastroscopy is always indicated. If the lesion on can be seen at gastroscopy, it can be correctly diagnosed, in the great majority of instances, with greater accuracy than by the use of x-rays. *John C. Meadows, M.D., and Edward J. Lefeber, M.D. Gastroscopy: A 14 Year Survey of Over* 1,000 *Consecutive Examinations. Ann. Int. Med. Jan.* 1954.

MEDICAL ECONOMICS



John R. Wolff, Chairman, Walter C. Bornemeier, Edward W. Cannady, Roland R. Cross, Jr., E. F. Dietrich, W. W. Fullerton, Edwin F. Hirsch, Frederic T. Jung, W. R. Malony, Caesar Portes, William Requarth, Frederick W. Slobe.

Nursing Scholarship

W. Robert Malony, M.D., Pittsfield*

THESE comments may benefit small hospitals where the nursing situation presents difficulty. Physicians are generally interested in the number of nurses working in a hospital because a lack of nursing personnel adversely affects the quality of hospital care a patient receives.

The program of the Illini Community Hospital in Pittsfield, Illinois, was initiated approximately seven years ago, and on a small scale, is comparable with the program of the Illinois Farm Bureau and the State Medical Society which encourages physicians to locate in rural areas. The two programs were developed at approximately the same time.

The program here is rather loosely organized and it is understood that a program instituted in another locality might be more formally outlined at its inception. We have been pleased at the results of our program as it is set up. This is a program of nursing scholarships. It has been the policy of the Hospital Board to make available to a high school graduate a nursing scholarship provided two qualifications are met:

(1) A desire to go into nurses training and (2) a need for financial assistance. If these two requirements are met the applicant is granted a scholarship in nursing. The Hospital Board has worked very closely with the Hospital Auxiliary in carrying out this program, with the advice of the Hospital Administrator. The Hospital Board offers one scholarship each year. One of the main permanent programs of the Hospital Auxiliary has also been the provision of one nursing scholarship each year. The scholarship is for all the basic fees including all charges for tuition, for books, for laboratory, for uniforms and social fees. No money is provided for other purposes.

The actual application for a scholarship is received by the Hospital Administrator. The Hospital Auxiliary has a committee which handles all applications received after having used the advice of the Hospital Administrator. If the applicant demonstrates the desire and the need then a scholarship will be provided. At those times when more than two applicants have been qualified then various service clubs, and individuals in the community have provided the extra scholarships needed. There is one other requirement as far as the scholarship is concerned that the person receiving the training agrees to return to our local hospital and spend at least one year on the nursing staff as a repayment for the scholarship.

At the begining of the program this was handled simply as an oral agreement. More

**Present address: 1107 Medical Arts Building, Omaha 2, Nebr.*

recently an informal written agreement is signed by the applicant so that there will be no misunderstanding on the provisions of the scholarship.

Since this program has been in effect, two of the girls who started nurses training dropped out to get married before they completed the course, and a third finished the course, got married and stated that she did not wish to fulfill the agreement. In all three cases the amount of money which had been given as a scholarship was repaid by the individual who did not fulfill the final requirement of the scholarship. We now have five graduate nurses working at the hospital who have completed their scholarships, and have returned for duty in the hospital. Two of these have been at the hospital for approximately three and one half years since completing their nurses training.

One young man who had finished high school and expressed a desire to become a male nurse was sent through the program but we do not feel this procedure should be repeated. With the present set up as far as armed services is concerned the male student has too little probability of returning to the hospital for his one year service. Actually, in our case the individual requested permission to continue training as a nurse anesthetist, which he did, and graduated as a nurse anesthetist. After he had completed that course the local hospital found they were unable to use his services for the required year and consequently he was released from his obligation although he was willing to fulfill it.

At present six students are away on nursing scholarship; one who will return next fall, two the following year, and three will return who are now in their first year of nurses' training. Several applications for scholarships are on file for training next fall.

This program is presented with the idea that it can be adopted in other localities to relieve the shortage of nurses which apparently exists in small hospitals. Certainly the local hospital would be short staffed in the nursing department if we did not have the nurses working now who have completed this program.

‹ ‹ ‹ › › ›

More on lung cancer

The increase in incidence of bronchogenic cancer is not limited to the United States but is seen throughout the civilized world. In Holland, for instance, from 1924 to 1951, there was a 24 fold increase in the incidence of lung cancer deaths in men and a 10 fold increase in women during the same period of time. In 1931, cancer of the lung represented 0.5 per cent of all deaths in England and Wales in males whereas in 1952, this percentage had increased to 5 per cent. In 1931, cancer of the lung represented 5 per cent of all cancer deaths and in 1952, this percentage had increased to 26. In England during the year 1950, 4 per cent of all the male deaths were due to cancer of the lung and between the ages of 45 and 54, 10 per cent of the deaths in males were due to this disease. *Alton Ochsner, M.D. Relationship of Cigarette Smoking To Lung Cancer. Rocky Mountain M. J. Feb.* 1955.

CORRESPONDENCE



Clinics for crippled children listed for July

Twenty four clinics for Illinois' physically handicapped children have been scheduled for July by the University of Illinois Division of Services for Crippled Children. The Division will count 18 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social and nursing service. There will be 5 special clinics for children with rheumatic fever and 1 for cerebral palsied children.

Clinics are held by the Division in cooperation with local medical and health organizations, both public and private. Clinicians are selected among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or may want to receive consultative services.

The July clinics are:

July 6 — Hinsdale, Hinsdale Sanitarium

July 6 — Carrollton, Carrollton Grade School

July 7 — Flora, Clay County Memorial Hospital

July 7 — Sterling, Field House

July 8 — Chicago Heights (Rheumatic Fever), St. James Hospital

July 12 — Peoria, Children's Hospital

July 12 — E. St. Louis, St. Mary's Hospital

July 13 — Joliet, Will County T. B. Sanitorium

July 14 — Springfield, St. John's Hospital

July 14 — Cairo, Public Health Building

July 14 — Elmhurst (Rheumatic Fever), Memorial Hospital of DuPage County

July 19 — Quincy, St. Mary's Hospital

July 15 — Evanston, St. Francis Hospital

July 19 — Danville, Lake View Hospital

July 20 — Alton (Rheumatic fever all day, General Orthopedic A. M.), Alton Memorial Hospital

July 20 — Evergreen Park, Little Company of Mary Hospital

July 21 — Rockford, St. Anthony's Hospital

July 22 — Chicago Heights, (Rheumatic Fever), St. James Hospital

July 26 — Peoria, Children's Hospital

July 26 — Effingham (Rheumatic Fever), St. Anthony's Hospital

July 27 — Springfield (Cerebral Palsy), Memorial Hospital

July 27 — Aurora, Copley Memorial Hospital

July 28 — Bloomington, St. Joseph's Hospital.

July 28 — Mt. Vernon, Masonic Temple

‹ ›

Rocky Mountain Cancer Conference

The Rocky Mountain Cancer Conference will be held in Denver, July 13-14, 1955. The program is now being arranged and it will be an outstanding one. Elmer Hess, as President of the American Medical Association will be on the program, as will Jerrold Nesselrod. A number of other prominent men in the field of cancer control will appear on the program.

For further information and the official program, write to Mr. Harvey T. Sethman, Executive Secretary, Colorado State Medical Society, 835 Republic Building, Denver 2, Colorado.

Competition with the professor

If clinical teachers in significant numbers are to be paid full time salaries by their medical school, then that school also must be tax supported or be permitted to engage in the general practice of medicine and collect from patients the fees needed to pay the staff salaries. If clinical teachers are to be paid partial salaries by their medical school and then permitted to organize under their own leadership a group practice arrangement which will enable them to supplement their medical school salaries (the geographic full time arrangement), the school can thereby provide itself at a reasonable cost with a clinical teaching staff always available at the teaching hospital, and without itself actually entering the general practice of medicine. While this latter arrangement satisfies the requirements of the law it still may, unless proper safeguards are set up, operate in such a way as to place the school-connected physicians in such a favored competitive position over that afforded the local practicing physicians that it becomes an obvious example for every student to note of unethical professional practice. *Editorial. Medical Schools in the Practice of Medicine. Pennsylvania M.J. April* 1955.

‹ ›

The value of the admission test

The Medical College Admission Test serves several useful purposes. Since almost all applicants to medical schools in the United States take this test, it enables each student to be compared with all other students on a common standard. Since different colleges use different standards of grading, a comparison of the raw marks is not satisfactory. A "B" average at one school might indicate more ability than an "A" average at another. Taking the Medical College Admission Test gives the exceptional student from a remote small college with which the committee has had little experience a chance to show how he compares with all other applicants throughout the country, regardless of their schools. *Daniel H. Funkenstein, Some Myths About Medical Schools Admissions. J. Med. Educ. Feb.* 1955.

Cardiac surgery

In patients with coronary artery disease, operation provides protection for the myocardium and relieves areas of ischemia responsible for pain. In properly selected patients, the operative and immediate postoperative mortality is less than 10 per cent. A much lower mortality rate probably cannot be achieved in view of the inherent mortality of the disease itself in the type of patient who presents himself for surgery, as demonstrated by the six deaths in patients awaiting surgery. Operation should be performed before there is extensive muscle destruction as a result of coronary disease. Long term evaluation of 32 patients reveals an excellent or good result in 69 per cent with some degree of improvement in 87.5 per cent. As of Oct. 1, 1954 there have been no deaths following the immediate postoperative period. It is concluded that the clinical improvement and protection afforded by operation associated with a low operative mortality justify the application of coronary surgery to properly selected patients with coronary disease. *Bernard L. Brofman, M.D. Results of Operation for Coronary Disease. Pennsylvania M.J. April* 1955.

‹ ›

No relationship

Although hypertensive patients show a high incidence of arteriosclerosis, experimental evidence so far does not establish that the one condition necessarily induces the other. *Murray Goldstein, M.D. Arteriosclerosis Studies. Pub. Health Rep. March* 1955.

‹ ›

Infectious hepatitis

Infectious hepatitis was added in 1952 to the list of diseases to be reported weekly, but notification was known to be incomplete for that year. During the following two years, reporting was much improved and probably was better in 1954 than in 1952. The provisional number of cases reported in 1954 is 49,739 compared with 33,383 in 1953. The large number of cases reported during these two years indicates that the disease is a major health problem. *Granville Sylvester and C.C. Dauer, M.D. Infectious Hepatitis,* 1953 *and* 1954. *Pub. Health Rep. March* 1955.

NEWS of the STATE

ADAMS

Quincy Medical PR News Inaugurated.—A new medical newsletter, the Quincy Medical PR News, was inaugurated in May. Its purpose is to promote better medical public relations as well as to present socio-economic aspects of medical practice in the Quincy tri-state area. The publication will be issued tentatively on a quarterly basis by the Swanberg Medical Foundation of the Adams County Medical Society. The medical foundation is an irrevocable trust set up by a member of the Adams County Medical Society in 1943 for the society. It is utilized to help sponsor the public relations program of the society. The new periodical is edited by Dr. Harold Swanberg, Quincy, editor of the Mississippi Valley Medical Journal and Radiologic Review, and secretary, Mississippi Valley Medical Society and the American Medical Writers' Association.

Personal.—Drs. Raymond E. Holben, Richard Meyer and Roy T. Rapp, all of Quincy, were elected to active membership in the Adams County Medical Society recently.

Society News.—The Adams County Medical Society was addressed recently by Dr. Harry A. Oberhelman, professor and chairman of the department of surgery, Stritch University School of Medicine at Loyola University on "Indications for Surgical Intervention in Diseases of the Intestines that are Being Treated Medically." The April 11 meeting of the society was addressed by Dr. Edward O. Kraft, chief of anesthesia, St. Luke's Hospital, St. Louis,

ALEXANDER

Dr. Baur Chosen Mayor.—Dr. Paul S. Baur was elected mayor of Cairo, Tuesday, April 20. A graduate of the University of Arkansas School of Medicine, Little Rock, Dr. Baur defeated Guy Coleman by a vote of 3,080 to 2,272, a majority of 808 in the unofficial returns. Dr. Baur was inducted into office May 2.

CLINTON

Society News.—Dr. F. Garm Norbury, Jacksonville, President of the Illinois State Medical Society, discussed "Nervous System Disorders in General Practice" before the Clinton County Medical Society, April 3. The Society was addressed in March by Dr. Stuart B. Mauch, Belleville, on "Diagnosis of Urological Conditions from Other Abdominal Pathologies."

COOK

Institute for Language Disorders in Children.—Northwestern University School of Speech has received a grant of $45,000 to establish an institute for language disorders in children, according to an announcement by Dean James H. McBurney. The grant came from the Wieboldt Foundation of Chicago. Helmer R. Myklebust, Northwestern professor of audiology, has been named director of the institute. He has been director of the children's hearing and aphasia clinic since 1950. The institute will study language disorders resulting from deafness, brain injury, and emotional disturbances. Primary emphasis will be given to children over two years of age who have not yet completed their early school years. In a news release, it was stated that the emphasis will be on the disorders and pathology of language, but it is anticipated that a body of knowledge will be forthcoming which will be relevant to the understanding of language development in all people. The institute will constitute a service for handicapped children, as well as a laboratory and training facility for studies in speech pathology and audiology.

The Borden Awards of the Pediatric Society.—The Chicago Pediatric Society devoted its meeting April 19 to a program sponsored by the Borden Company. The residents whose papers were considered of the most value were: Drs. Vlastimil Vrla, Cook County Hospital, "Electrocardiographic Studies in Premature Infants"; Natalie Schuckmell,

University of Illinois, "The Differential Diagnosis of Operable Portal Obstruction in Children"; Robert M. Kohlenbrener, Michael Reese Hospital, "Infantile Diarrhea Due to Pathogenic Serogroups of E. Coli"; and Robert A. Lussky, Children's Memorial Hospital, "A Study of The Use of Lente Insulin in Diabetic Children". The four residents divided the sum of $250 received through the Borden Company. This residents' program is sponsored annually by the Chicago Pediatric Society. At the meeting, Drs. Howard Weiss, Sumner Hagler and Lester A. Nathan were voted into the Society as associate members.

Branch Meeting.—At the May 3 meeting of the North Shore Branch of the Chicago Medical Society, the speakers were Drs. John R. Adams, associate in neurology and psychiatry, Northwestern University Medical School on "Trauma and The Psychiatrist", and William A. Larmon, associate in the department of orthopedic surgery, "Intramedullary Fixation of Fractures."

The Davis Lecture.— Dr. Ralph H. Major, professor of the history of medicine, University of Kansas School of Medicine, Kansas City, delivered the twelth David J. Davis Lecture in the History of Medicine, at the University of Illinois College of Medicine, May 11. Dr. Major's subject was "Etruria and Etruscan Medicine."

Food Facts For Diabetics.—The Service Unit of the Chicago Diabetes Association sponsored a meeting at the Murphy Memorial Auditorium of the American College of Surgeons, May 13, on "Food Facts For Diabetics." Speakers were: Dr. Arthur Colwell, past president of the American Diabetes Association, on "The Need For A Diabetic Diet"; Mrs. Anna Boller Beach, director of Nutrition and Dietetic Clinic, Central Free Dispensary, Presbyterian Hospital, "Planning The Diabetic Diet Around the Family Menu"; Mrs. Helen Means Proctor, dietitian in Pediatrics Department, Billings Hospital, "Diet Of Child At Home And At Camp"; and Mrs. Ida Wydes, head of the Dietary Department, Mandel Clinic, Michael Reese Hospital, on "General Foods For Diabetics."

Changes in Faculty.—Dr. David M. Cohen has been appointed chairman of the department of dermatology and syphilology at the Chicago Medical School. Dr. Cohen, who has been acting chairman of the department, has been a member of the faculty since 1937. Other appointments include the following: Dr. Frank E. Rubovits, clinical assistant professor of gynecology and obstetrics; Dr. Jerome J. Moses, clinical associate in surgery; Dr. Carl Weiner, clinical assistant in medicine; Dr. Irene Kuras, clinical assistant in Pediatrics; John McAllister, Clinical Assistant in Psychiatry; Dr. Walter Indeck, clinical instructor in orthopedic surgery; Dr. Philip Falk, instructor in orthopedic surgery; and Dr. Minnie Frank, clinical assistant in pediatrics. Promotions on the faculty include the following: Dr. Irving Wolin, clinical associate professor of orthopedic surgery; Dr. Allan B. Hirschtick, clinical assistant professor of orthopedic surgery; and Dr. LeRoy P. Levitt, assistant professor of psychiatry.

Grants For Research.—New and renewed grants for various research studies at The Chicago Medical School include:

Dr. Philippe Shubik, coordinator of oncology, has been awarded $25,000 from the National Cancer Institute and $5508 from the American Cancer Society of Illinois for continuance of his cancer research program. Dr. Hans Elias, associate professor of anatomy, has also received a grant from the National Cancer Institute of $11,620, a two year renewal for his study of liver cancer.

A renewal of $7884 from the National Institute of Arthritis and Metabolic Diseases has been granted to Dr. Piero P. Foa, professor of physiology and pharmacolgy, for continuance of his studies on experimental diabetes. The George Brandwein Foundation has given a renewed gift of $2000 to Dr. Aldo A. Luisada, director of the division of cardiology, for cardiovascular research. Dr. Luisada has also received grants from Sandoz Pharmaceuticals for $1500 and from Lincoln Laboratory for $350.

Dr. Jay A. Smith, associate professor of physiology and pharmacology, has been awarded two grants; $880 from the Life Insurance Medical Fund for studying the effects of ouabain on embryonic heart metabolism, and $367.50 from the Chicago Heart Association to carry on experimentation with the cartesian diver. Doctors Abe. L. Aaronson and Morris A. Kaplan, assistant professors of medicine, have received $600 for allergy research.

Personal.—Dr. Irene Neuhauser, clinical associate professor of dermatology, University of Illinois College of Medicine, recently became the first woman president of the Chicago Dermatological Society. Dr. Neuhauser, who has also served as secretary-treasurer and vice president of the Society, is especially interested in the study of tropical skin disease. She is a graduate of Rush Medical College.

Prize Honors Physician's Brother.—The Harry Abrahams Prize in Multiple Sclerosis has been established by Dr. Sam Abrahams in honor of his brother, Mr. Harry Abrahams. The fund of $350 is to be used as an award for papers on studies in multiple sclerosis submitted by any person in training. The first prize will be $200, and the second $150. Anyone interested in submitting a manuscript should write to the Secretary of the Chicago Neurological Society, Dr. Oscar Sugar, 912 South Wood Street, Chicago 12. If accepted, the winning manuscript will be read at one of the regular meetings of the Chicago Neurological Society. If several are submitted, they will be placed before a committee to judge the first and second best.

Northwestern Student Receives Prize.—Richard E. Land, a medical school junior of Northwestern University Medical School won first prize in a national contest sponsored by the Schering Corp. of Bloomfield, New Jersey. The award was presented by Carl H. Suding, manager of the firm's Chicago division. Land, who received the prize for an article on "Modern Treatment of Infections and Allergic Disorders of the Eye", is the son of Mrs. H. B. Levine, of Glendale Road, Marblehead, Massachusetts.

School Receives Gift.—A gift of $500 has been received by The Chicago Medical School from the Dr. Howard Sloan Memorial Research Fund in commemoration of Dr. Sloan's birthday, April 2. Since the fund was established by friends of the late Dr. Sloan in 1953, The Chicago Medical School has received this annual gift, which is applied to the Dr. Howard Sloan Physiology Research Grant. Dr. Sloan, a 1942 alumnus of the school, died June 15, 1952. At the time of his death he was a Fellow in the Department of Physiology, performing research on the artificial kidney.

The Zeit Memorial Lecture.—Dr. Maxwell M. Wintrobe, professor and head of the department of internal medicine, University of Utah College of Medicine, delivered the Twelfth Annual F. Robert Zeit Memorial Lecture, May 4, in Thorne Hall on the Chicago campus of Northwestern University. Dr. Wintrobe's subject was "Blood Production, Blood Destruction, the Spleen and Splenectomy." The lecture was sponsored by the student and alumni members of Alpha Kappa Kappa at Northwestern University Medical School.

Heart Meeting.—The Chicago Heart Association was addressed May 17 by Dr. Earl A. Zaus, associate professor of medicine, Northwestern University Medical School, on "Abuses In The Treatment of Congestive Heart Failure." Discussion was presented by Dr. William S. Hoffman, professorial lecturer in medicine, University of Illinois College of Medicine. At the Clinical Pathological Conference, Dr. Hans Popper, director of department of pathology, Cook County Hospital, presented a case. Dr. Wright R. Adams, professor and chairman of department of medicine, University of Chicago School of Medicine, opened the discussion. Dr. Walter S. Priest, chairman, professional education committee, Chicago Heart Asociation, presided.

Special Society Meetings.—Dr. John W. Ferrin, delivered the presidential address at the Annual Meeting of the Chicago Urological Society, April 28. His subject was "Vaginal Urethral or Female Hypospadias." Other speakers were Drs. A. W. Kneucker, Chicago Medical School, on "Electrourogram" and David Presman and Raymond Firfer, "A Diagnostic Technique for Retrocaval Ureter."

— The Chicago Rheumatism Society was addressed April 27, by Drs. Thomas D. Brower, David Ruml and D. M. Bergenstal, on "Rupture of Extensor Pollicis Longus in Rheumatoid Arthritis," and Dr. Douglas A. MacFadyen, on "The Chemistry of Intercellular Material" and I. Pilot, "Mixed Collagen Diseases." — The Chicago Society of Physical Medicine and Rehabilitation was addressed April 27 by Dr. Ralph E. De Forest, secretary of the council on Physical Medicine and Rehabilitation who covered the program of the council and Dr. Ben L. Boynton, medical director, Rehabilitation Institute of Chicago, "Preliminary Report on Ultrasonic Therapy in Osteo-arthritis."

DOUGLAS

Society News.—Dr. Hyman J. Burstein, Decatur, addressed the Douglas County Medical Society at the Jarman Hospital, Tuscola, recently on "Common Tumors of Skin and Their Treatment."

KNOX

Personal.—Dr. Thomas Tourlentes, assistant superintendent of the Galesburg Research Hospital, was recently elected to membership in the Knox County Medical Society.

LAKE

Society News.—Dr. Heinrich Nechles, Director of Gastrointestinal Research, Michael Reese Hospital, Chicago, addressed the Lake County Medical Society at the Deerpath Inn, Lake Forest, April 12, on Gastrointestinal Therapy Based on Recent Research Studies.

MACON

Society News.—"Usefulness of Urinary Steroid Determination" was the subject of Dr. Ralph A. Kinsella, Jr., associate professor of internal Medicine, St. Louis University School of Medicine, before the April 26 meeting of the Macon County Medical Society at the Decatur Club.

MADISON

Society News.—Dr. William Middleton, Alton, instructor in clinical ophthalmology at Washington University School of Medicine addressed the Madison County Medical Society at St. John's Methodist Church, Edwardsville, April 7, on "Recent Advances in Diagnosis and Treatment of Glaucoma."

PEORIA

Peoria Annual Meeting on Mental Health.—Dr. Harvey Tompkins, chief of neurology and psychiatric Service of the Veterans Administration, addressed the annual dinner meeting of the Peoria Mental Health Society, May 4, at the Jefferson Hotel. The society sponsored a number of radio and television activities during the week beginning April 30, highlighting various aspects of mental Health.

Symposium on Low Back Pain.—The Peoria

Medical Society devoted its meeting, April 19, at the University Club, to a Symposium on Low Back Pain. Speakers were Drs. C. J. Heiberger, Fred Stuttle and Joseph Schaeffer, all of Peoria.

ROCK ISLAND

Society News.—Dr. Ward Eastman, Peoria, spoke before the Rock Island County Medical Society at St. Anthony's Hospital, Rock Island, April 12. His subject was "New Concepts in Colon Surgery."

ST. CLAIR

Society News.—Dr. Don C. Weir, associate clinical professor of radiology, St. Louis University School of Medicine, St. Louis, discussed "The Valuation of Accuracy in Roentgenological Diagnosis" before the St. Clair County Medical Society, at a dinner meeting, May 5, at the Pleasant View Sanatorium, Belleville.

Cahokia Chapter of the Academy of General Practice Reactivated.—Officers of the recently reactivated Cahokia Chapter of the Illinois Academy of General Practice are; Dr. J. Hipskind, President; Dr. Robert Little, vice president; Dr. Wayne B. Cox, Secretary and Dr. Roy Culbertson, treasurer. Some twenty to thirty physicians have been in attendance at each of the last two meetings, it was reported in the Bulletin of the St. Clair County Medical Society.

SANGAMON

Society News.—Dr. O. H. Beahrs, assistant professor of surgery, The Mayo Foundation, addressed the Sangamon County Medical Society at the Elks Club in Springfield, April 7, on "Treatment of Carcinoma of the Head and Neck."

VERMILION

Society News.—Dr. B. Todd Forsyth, a member of St. Luke's Hospital, St. Louis, discussed "Treatment of Uremia" before the Vermilion County Medical Society at the Veterans Facility, Danville, April 5.

GENERAL

Clinical Meeting of Academy of Surgery.—On May 16, the Illinois Academy of Surgery conducted a clinical meeting at the Cook County Hospital. The following participated:

Karl A. Meyer, Surgery of the Stomach; Raymond W. McNealy, Surgery of the Neck; Peter A. Rosi, Surgery of the Colon; James J. Callahan, Fractures and Trauma; Carlo Scuderi, Orthopedic Surgery; Manuel E. Lichtenstein, Surgery of the Biliary System; George W. Holmes, Thoracic Surgery; Louis P. Rivers, Surgery of the Breast; Arkell M. Vaughn, Vagotomy and Gastroenterostomy; Leon J. Aries, Surgery of the Thyroid; Egbert H. Fell, Surgery of the Heart; Richard H. Lawler, Proctosigmoidectomy with Sphincter Control; Samuel J. Fogelson, Gastric Surgery; John Keeley, Pediatric Surgery; and William M. McMillan, Use of Osteoperiosteal Flap in the Repair of Recurrent Direct Hernia.

County Releases Annual Report.—The 1954 Annual Report of the Cook County Department of Public Health has recently been published. Prepared in booklet form, the report is replete with illustrations and texts covering various phases of the department under the directorship of Dr. John B. Hall. The sections are devoted to Maternal and Child Health Program, Rehabilitation, School Health, Professional Education, Communicable Disease Control, Environmental Health, Nursing Homes, Veterinary Medicine and Vital Statistics. The report also shows a breakdown in budget allocations.

British Anesthesiologists Address Regional Meeting.—On Sunday, June 12, 1955, the anesthesiologists of Illinois, Indiana, Iowa, Michigan, Minnesota and Wisconsin met at the John B. Murphy Memorial Hall of the American College of Surgeons, 40 East Erie Street, Chicago. Speakers were Geoffrey S. W. Organe, M.D., president Association of Anesthetists of Great Britain and Ireland; director, Department of Anesthetics, Westminster Hospital, London, England, on "Polypharmacy in Anesthesia"; Sheila M. Anderson, M.B., chief Neuro-Surgical Anesthetist, St. George's Hospital; staff anesthetist Moorfields Eye Hospital and Great Ormond Street Children's Hospital, London, England, on "Pediatric Anesthesia"; Andrew R. Hunter, M. D., Department of Anesthesia, The Royal Infirmary, University of Manchester, Manchester, England, on "Second Thoughts on Spinal Anesthesia"; Ronald Jarman, D.S.C., Senior Anesthetist to the Gordon Hospital, (Westminster Group) and Princess Beatrice Hospital (Chelsea Group), Anesthetist to the Royal Marden Hospital, London, England, on "The Use and Misuse of Intravenous Needles".

"Your Doctor Speaks" over FM Station WFJL.—The following have recently participated in the series" Your Doctor Speaks" over FM Station WFJL under the auspices of the **Educational Committee** of the **Illinois State Medical Society:**

John L. Archibald, member of the staff, St. George's Hospital, Premarital Counseling.

Beulah Bosselman, clinical associate professor of psychiatry, University of Illinois College of Medicine, Neurotic Anxiety.

Edward J. Beattie, chairman of the department of surgery, Presbyterian Hospital, Cancer of the Lung.

Edward F. Scanlon, associate attending surgeon, Evanston Hospital, Cancer of the Breast.

Arthur A. Halevy, member of the staff of Columbus Hospital, Asthma.

Louise Tavs, clinical assistant professor of dermatology, University of Illinois College of Medicine, Care of the Skin.

Charles S. Gilbert, clinical assistant in medicine, Stritch School of Medicine of Loyola University, Diet and Disease.

Fred V. Hein, Ph.D., consultant in health and fitness, Bureau of Health Education, American Medical Association, Exercise.

Edwin F. Hirsch, director of laboratories, St. Luke's Hospital, Why An Autopsy.

Edwin R. Levine, assistant clinical professor of medicine, Chicago Medical School, Tuberculosis.

Kurt Eichelbaum, clinical assistant professor of the department, department of orthopedic surgery, University of Illinois College of Medicine, Your Troubled Back.

"All About Baby" on WGN-TV, Channel 9.— The following have appeared on the telecast "All About Baby" on WGN-TV, Channel 9, under the auspices of the **Educational Committee** of the **Illinois State Medical Society.** The telecast, a Jules Power Production, features Ruth Crowley, R. N.

Helen C. Hayden, member of the pediatric staff, St. Luke's Hospital, April 20, Allergies.

R. E. Kadens, D.D.S., a member of the Chicago Dental Society, April 27, Care of the Teeth in the Young Child.

Daniel J. Packman, clinical assistant professor of pediatrics, University of Illinois College of Medicine, Immunization and Communicable Diseases.

John L. Keeley, professor of surgery, Stritch School of Medicine of Loyola University, Surgery and the Child.

Elmer W. Hagens, associate professor of otolaryngology, Northwestern University Medical School, May 18, on All About Hearing.

Lectures Arranged Through the Educational Committee of the Illinois State Medical Society:

Emily C. Cardew, R. N., director, University of Illinois School of Nursing, Hinsdale Hospital School of Nursing, Hinsdale, Civilian Defense (The Nurse's Role During an Air Raid).

George V. Byfield, thirty-second Annual Midwestern Safety Conference, May 3, Growing Useful While Growing Old.

Joseph K. Freilich, Chicago Jewish Academy, May 5, Effects of Smoking.

John O. Firth, Monmouth, St. Mary's Home and School Association in Canton, May 13, Why A Case History.

Jerome S. Beigler, Woman's Auxiliary to Cook County Physicians' Association in Chicago, May 28, on Mental Health and Attitudes.

"Youth Week Lectures."—The following physicians cooperated in the Youth Week program conducted by the Chicago Medical Society in conjunction with the Chicago Board of Education. The lectures were arranged through the **Educational Committee** of the **Illinois State Medical Society:**

J. Joseph Baratz, Mulligan Elementary School, May 9, on How Temperamental Are You?

Sol P. Ditkowsky, Ebinger Elementary School May 9, on How Temperamental Are You?

Robert E. Lee, Healy Elementary School, May 9, Health and Personality.

Paul K. Anthony, Yale Elementary School, May 9, Building Body, Bones and Beauty.

Paul J. Cella, John H. Hamline Elementary School, May 11, How Temperamental Are You?

Irving H. Rosenthal, Yates Elementary School, May 11, Health and Personality.

Clarence J. Barasch, Yates Elementary School, May 11, How Temperamental Are You.

John L. Archibald, Fuller Elementary School, May 11, Teen Age Tips on Health.

Robert K. Hagan, two assemblies at the Sherwood Elementary School, May 13, Keeping Solid with Health and Teen Age Tips on Health.

Alfred D. Biggs, two assemblies at the Sherwood Elementary School, May 13, on Keeping Solid with Health and Teen Age Tips on Health.

Lectures Arranged Through the Scientific Service Committee of the **Illinois State Medical Society:**

Boris B. Rubenstein, Chicago, Kane County Medical Society in St. Charles, April 13, on Reproductive Disturbances, Especially in the Diagnosis and Treatment of the Infertile Couple.

Edwin J. Holman, L.L.B., Chicago, Macoupin-Montgomery County Medical Societies and attorneys of both counties in Carlinville, May 24, on Let's Understand Each Other.

W. W. Bauer, Chicago, La Salle County Pharmaceutical and La Salle County Medical Society in La Salle, May 25, on Odds and Ends.

Lindon Seed, Chicago, Lee-Whiteside County Medical Societies at the Plum Hollow Country Club in Dixon, May 26, on Present Status of Diagnosis and Therapy of Diseases of the Thyroid.

George M. Cummins, Chicago, Kane County Medical Society in St. Charles, June 8, on Cardiovascular Aspects of Aging.

‹ ›

DEATHS

Arpad M. Barothy*, Chicago, who graduated at Rush Medical School in 1894, died April 29, aged 85.

Andrew J. Butner*, Harrisburg, who graduated at Northwestern University Medical School in 1908, died March 7, aged 78.

Chauncey W. Cargill*, Mason City, who graduated at the College of Physicians and Surgeons of Chicago in 1889, died February 20, aged 89, of heart disease. He had served as district health superintendent.

Jason D. Chittum*, Sorento, who graduated at Keokuk Medical College in 1891, died March 12, aged 94. He had been a member of the "Fifty Year Club" of the Illinois State Medical Society, since 1941.

John Webster Cornell, Chicago, who graduated at the Hahnemann Medical College and Hospital in 1900, died February 12, aged 79.

*Member of the Illinois State Medical Society

Julian Dawson, retired, Chicago, who graduated at Northwestern University Medical School in 1914, died May 5, aged 68.

Edwin L. Dunston*, Chicago, who graduated at Medizinische Fakultät der Universität, Wien, Germany, in 1923, died April 15, aged 59. He was a member of the staff of the American Hospital.

Milo T. Easton*, Peoria, who graduated at Northwestern University Medical School in 1906, died in April, aged 71.

William Otto Fish*, Fillmore, who graduated at Medical College of Kansas City in 1911, died March 28, aged 73.

John L. Klemme, retired, Joilet, who graduated at the College of Physicians and Surgeons, Chicago, in 1890, died March 1, aged 87, of acute myocardial infarction.

John V. Lambert*, Chicago, who graduated at Loyola University School of Medicine in 1922, died April 11, aged 71.

Rollin Harold Lester*, Morrison, who graduated at the University of Illinois College of Medicine in 1927, died in St. Mary's Hospital, Rochester, Minnesota, March 1, aged 53, of bronchopneumonia and glioma of the brain. He was a past president of the Whiteside County Medical Society.

Ignatius E. Makar*, Chicago, who graduated at Loyola University School of Medicine in 1919, died April 16, aged 59.

David H. McCarthy*, Springfield, who graduated at Loyola University School of Medicine in 1912, died March 27, aged 68. He had practiced medicine in Springfield forty-three years.

Bernard Mantell*, Maywood, who graduated at Loyola University School of Medicine in 1939, died in St. Mary's Hospital, Rochester, Minnesota, February 18, aged 43, of heart failure and hypertension.

John E. Miller*, Quincy, who graduated at Baltimore Medical College in 1893, died April 5, aged 84.

Samuel Lewis Morgans, Oak Park, who graduated at the State University of Iowa College of Medicine in 1898, died in MacNeal Hospital, Berwyn, January 22, aged 79, of pneumonia.

John C. Murphy*, Ridgeway, who graduated at St. Louis University School of Medicine in 1905, died March 12, aged 79.

Fred A. Paradise*, Oak Park, who graduated at Loyola University School of Medicine in 1931, died April 11, aged 66.

Stephen Polyak, Chicago, who graduated at the University of Odessa Faculty of Medicine, Russia, in 1916, died March 9, aged 65, of myocardial infarction. He was professor of anatomy at the University of Chicago School of Medicine.

Gordon W. Raleigh*, Evanston, who graduated at Northwestern University Medical School in 1942, died April 13, aged 41. He was former director of the graduate division of Northwestern University Medical School.

Leo E. Schneider*, Oregon, who graduated at Rush Medical College in 1901, died recently, aged 77.

Albert William Seidel*, Park Ridge, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1903, died April 3, aged 74. He was a member of the "Fifty Year Club" of the Illinois State Medical Society.

Frank H. Stevenson*, retired, Chicago, who graduated at Rush Medical College in 1904, died April 16, aged 79.

Isadore M. Trace*, Chicago, who graduated at Northwestern University Medical School in 1909, died May 4, aged 75. He was one of the founding physicians of Mount Sinai Hospital and professor of clinical medicine at the Chicago Medical School.

*Member of the Illinois State Medical Society.



Particularly now...

Why is **KENT** the one fundamentally different filter cigarette?

more brands of filter cigarettes that troduced—the more innovations in ng—the clearer becomes the differ- KENT. Consider for a moment why. y KENT, of all filter brands, goes to tra expense to bring smokers the s Micronite Filter. All others rely on cotton, paper or some form of se.

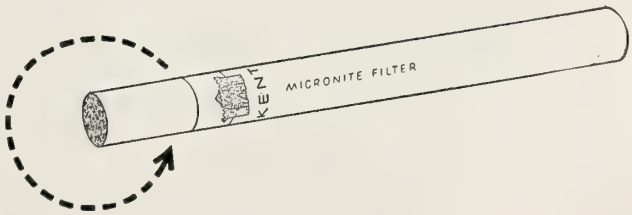
Indeed, the material in KENT's Micronite Filter is the choice in *many* places where filter requirements are most exacting.

With such filtering efficiency, it is understandable why KENT with the Micronite Filter takes out even microscopic particles —why KENT is *proved* effective in impartial scientific test after test.

Taste will tell the rest of the story. For KENT's flavor is not only light and mild. It stays fresh-tasting, cigarette after cigarette.

May we suggest you evaluate KENT for yourself, doctor? We firmly believe that, with the first carton, you will reach the same conclusion. As always, there is a difference in KENT. And now more than ever before.

KENT
with exclusive
MICRONITE FILTER





The pleasant cinnamon flavor of this children's sulfa tablet carries clear through—no bitter after-taste. Children will accept your therapy gladly because Demisulf can be chewed or will disintegrate rapidly in a teaspoonful of water.

Doctors have found Demisulf most successful for treating their young patients with a well balanced sulfa combination.

Sulfadiazine	*0.083 Gm.*
Sulfamerazine	*0.083 Gm.*
Sulfamethazine	*0.083 Gm.*
(Represents Total Sulfonamides	*0.250 Gm.)*

Try Demisulf for your next young patient. Send for your free testing sample today.

Please send me my testing sample of Demisulf along with complete information.

Name_____

Street_____

City_____ Zone____ State_____

YATES DRUG COMPANY

295-303 Lafayette Street, New York 12, N. Y.

Treatment of tuberculous lymphadenitis

A Report by the Comm. on Therapy, American Trudeau Society, the American Review of Tuberculosis, November, 1954.

The treatment of tuberculous lymphadenitis has received little study since the introduction of specific antimicrobial therapy, as compared with the treatment of pulmonary tuberculosis and of other forms of extrapulmonary tuberculosis. This comparative neglect probably results from the relative infrequence of tuberculosis of the lymph nodes as a presenting manifestation of tuberculosis; and from the widespread impression that when it does so present itself, especially as an apparently localized infection of superficial nodes, it is less serious than most other forms of tuberculosis in the human.

As a consequence, the recent literature concerning the treatment of tuberculous lymphadenitis is sparse, especially with regard to the results of antimicrobial therapy. Not only is there no consensus regarding the optimum treatment, but there is scarcely any formulated opinion except that of surgeons and radiologists, who are concerned primarily with the local aspects of treatment by excision or by roentgen irradiation. A recent analysis, however, of all the patients with tuberculosis of the superficial lymph nodes discharged from the Toronto Hospital for Tuberculosis in the twenty-year period 1932-1952 indicates that this is uncommonly a localized form of tuberculosis and no longer predominantly a disease of childhood, which it was earlier, when the excisional treatment of cervical lymph node tuberculosis was perfected. The principle of the complete removal of all involved nodes and cold abscesses has been followed by more recent advocates of the surgical excision of superficial lymph node tuberculosis.

There appears to be no doubt that tuberculosis of the superficial lymph nodes can be effectively treated by excision so far as the local result is concerned. There is also evidence that roentgen irradiation is often locally effective and that, with the lower dosages recently employed, the hazards are not great. Reports of late follow-up results of these forms of treatment are limited, and there is little recognition of the possibility that superficial lymph node tuberculosis has become more commonly a manifestation of generalized tuberculosis than it was earlier. Yet in

(*Continued on page* 48)

When you specify the Pfizer antibiotic of your choice *Stress Fortified* with the B-complex, C and K vitamins recommended by the National Research Council, be sure to write SF on your prescription



antibiotics *Stress Fortified* with vitamins include:

®Terramycin-SF

Brand of oxytetracycline with vitamins

CAPSULES 250 mg.

®Tetracyn-SF

Brand of tetracycline with vitamins

CAPSULES 250 mg.

ORAL SUSPENSION (fruit flavored)
125 mg./5 cc. teaspoonful

℞

Tetracyn-SF
caps #16
Sig: One capsule,
q.i.d.

The minimum daily dose of each antibiotic *(1 Gm. of Terramycin or Tetracyn, or 600,000 units of penicillin)*
Stress Fortifies the patient *with the stress vitamin formula* **recommended by the National Research Council:**

Ascorbic acid, U.S.P.	300 mg.	Calcium pantothenate	20 mg.
Thiamine mononitrate	10 mg.	Vitamin B_{12} activity	4 mcg.
Riboflavin	10 mg.	Folic acid	1.5 mg.
Niacinamide	100 mg.	Menadione	
Pyridoxine hydrochloride	2 mg.	(vitamin K analog)	2 mg.

**Trademark*

Pfizer

PFIZER LABORATORIES, *Division, Chas. Pfizer & Co., Inc.*, Brooklyn 6, N. Y.



Tuberculosis (Continued)

the Toronto Hospital series 88 per cent of the patients had associated tuberculosis elsewhere in the body, most commonly in the lungs and in the bones and joints.

Both the surgical and the irradiation treatments are concerned principally with cervical lymph node tuberculosis and are predicated on the conception that tuberculosis of these lymph nodes is usually a localized form of tuberculosis, of which the portal of entry is the oro-pharynx. Tuberculosis of the tonsils, either from primary or reinfection, is held in this view to be commonly associated with or, indeed, responsible for the cervical lymph node tuberculosis. Pathologic evidence that this is now frequently the case is lacking. On the contrary, there is much to suggest the cervical, no less than axillary, intrathoracic, or abdominal lymph node tuberculosis is most often a manifestation of generalized tuberculous infection.

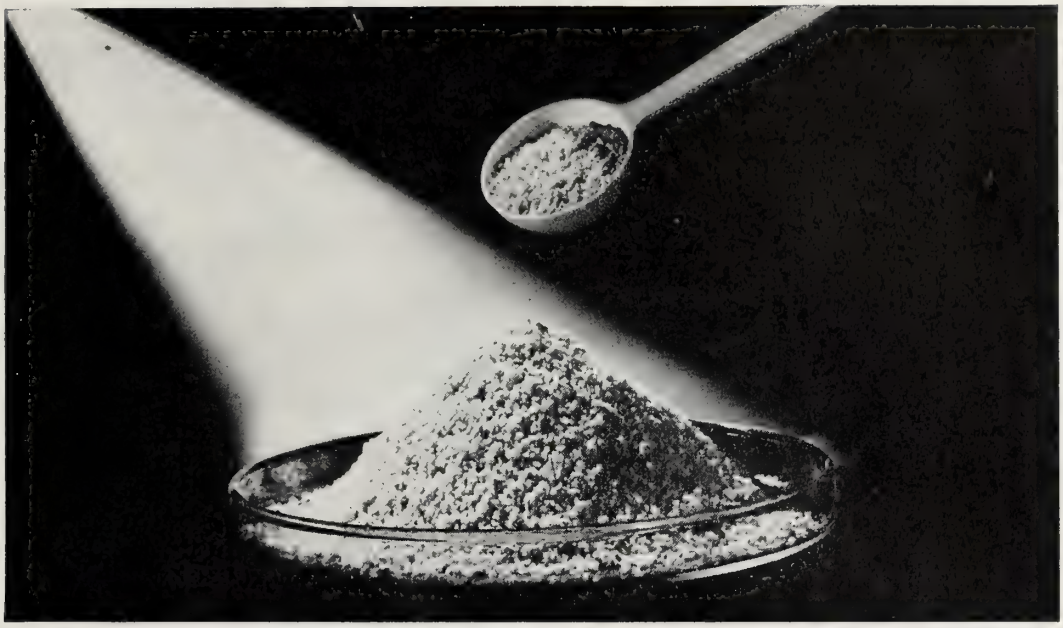
Regardless of whether or not cervical lymph node tuberculosis is often associated with tuberculosis of the tonsil, there is little reason to think that it is frequently caused by infection with tubercle bacilli of bovine origin. Even in 1910 careful studies by Park and Krumwiede showed that infection with tubercle bacilli of human origin predominated except in the age group of less than five years.

The available literature concerning the effect of antimicrobial therapy indicates merely: (1) that tuberculous lymphadenitis does tend to regress under such therapy, although often very slowly; and (2) that short-term, (up to 120 days) therapy is followed frequently by local relapse or the development of active foci elsewhere. The published reports relate almost exclusively to streptomycin or streptomycin PAS. Very few reports are available regarding long-term therapy, and even fewer regarding isoniazid therapy in this form of tuberculosis.

In view of the paucity of information regarding presently available forms of antimicrobial therapy, the Committee attempted to collect the experience of its own members and of others. The practice and experience of individual hospitals in the Veterans Administration were polled by the Committee thus adding greatly

(*Continued on page* 50)

FIRST REPORT



The spotlight of research is being turned on Lecithin — a natural phospholipid

Physiologic Role of Phospholipids

Phospholipids or phosphatides (lecithin, cephalin, sphingomyelin) are eliciting increased interest in medicine because they apparently are intimately connected with fat metabolism, and especially the transport of lipids in the blood. They are considered to function as emulsifying agents and stabilizers for fats and fat-like substances, such as cholesterol, in the blood serum.

How vital this function is will be evident from a view generally held by investigators that instability of the lipids in the serum-lipid emulsion is one of the most important contributing causes of atheromatous deposits in vessel walls.

An excellent source of lecithin is Glidden's "RG" Oil-free Soya Lecithin, a highly purified extract containing a minimum of 95% phospholipids. It is packed in a specially designed 8 oz container to maintain its purity and freshness and is available at your drugstore.

Dosage: Investigators of lecithin have used quantities from 7.5 to 30 grams daily in divided doses. (3 teaspoonfuls equal 7.5 grams.)

Administration: "RG" Lecithin is presented in palatable granules which may be taken plain, in milk, or sprinkled on cereal.

Literature available on request.

Bibliography: 1. Duff, G. L., and Payne, T. P. B.: J. Exper. Med. *92*:299 (Oct. 1) 1950. • 2. Schettler, G.: Klin. Wchnschr. *30*:627 (July) 1952. • 3. Gertler, M. M.; Garn, S. M. and Lerman, J.: Circulation *2*:205 (Aug.) 1950. • 4. Ahrens, E. H., and Kunkel, H. G.: J. Exper. Med. *90*:409 (Nov. 1) 1949. • 5. Boyd, E. M.: Proc. & Trans. Roy. Soc. Canada *31*:11 (May) 1937. • 6. Gertler, M. M., and Oppenheimer, B. S.: Geriatrics *9*:157 (April) 1954. • 7. Kellner, A.; Correll, J. W., and Ladd, A. T.: J. Exper. Med. *93*:385 (April 1) 1951.

GLIDDEN RG® LECITHIN

THE GLIDDEN COMPANY • CHEMURGY DIVISION
1825 North Laramie Avenue, Chicago 39, Illinois

QUALITY Glidden PRODUCTS

WE CORDIALLY INVITE YOUR INQUIRY for application for membership which affords protection against loss of income from accident and sickness (accidental death, too) as well as benefits for hospital expenses for you and all your dependents.



SINCE 1902

ALL PREMIUMS COME FROM

PHYSICIANS SURGEONS DENTISTS

ALL BENEFITS GO TO

$4,500,000 ASSETS
$22,500,000 PAID FOR BENEFITS

PHYSICIANS CASUALTY AND HEALTH ASSOCIATIONS
OMAHA 2, NEBRASKA

Tuberculosis (Continued)

to the volume of clinical material which could be considered.

The variability in treatment was so great that no statistical analysis of results could be attempted. The practice varied from the one extreme of surgical excision or roentgen irradiation with no concomitant antimicrobial therapy to the other extreme of long-term antimicrobial or simple rest treatment with no local treatment, except in exceptional circumstances. Those hospitals which employed long-term chemotherapy were satisfied with the effect on the lymph nodes themselves and usually reported a favorable result during the maintenance of therapy. No significant data on the incidence of post-treatment relapse were accumulated. The longer that excision of superficial lymph nodes was deferred, the less frequently was it considered necessary. Sinuses usually healed, and cold abscesses regressed, although frequently with the aid of needle aspiration. No comparisons were possible between isoniazid and streptomycin-PAS since, when isoniazid was used, it was usually in combination with other drugs. One observation of special interest is that even lymph nodes which break down or first appear during antimicrobial therapy usually regress satisfactorily if the therapy is continued unchanged. This has been noted both under combined therapy and under isoniazid as single-drug therapy.

The consensus of the Committee, based on the literature and the unpublished experience which was reviewed, is that antimicrobial therapy is indicated in virtually all instances of active tuberculous lymphadenitis, as in other clinical forms of tuberculosis. The evidence indicates, however, that short-term therapy is not adequate and that long-term therapy is not yet established as independently capable of permanently arresting the disease in most instances. The extent to which excisional surgery, roentgen irradiation, and prolonged rest therapy are needed is as yet entirely undetermined. There is much to suggest that the management of lymph node tuberculosis simply as a local disease process without systemic treatment is rarely, if ever, justified at the present time. The importance of rest and sanatorium treatment should

(*Continued on page* 52)

for Highest Potency • Wide Spectrum
Highest Blood, Plasma & Tissue Levels
Safety • Minimal Side Effects* • Economy

unexcelled among sulfa drugs . . .

*Few therapeutic agents, and none of the other sulfas, can claim the same degree of freedom from toxic side effects offered by the Triple Sulfas. The use of only a fractional dosage of each component sulfa drug reduces the possibility of undesirable side effects to an absolute minimum. No case of agranulocytosis has been reported resulting from their use.

Because they are so well tolerated, because of their wide spectrum of effectiveness and their outstanding economy, the Council-accepted Triple Sulfas are now more widely used than any single sulfa drug.

Triple Sulfas, alone or in combination with certain other agents, are available from leading pharmaceutical manufacturers under their own brand names. This message is presented on their behalf.

TRIPLE SULFAS

Meth-Dia-Mer Sulfonamides



All Sulfas are not Triple Sulfas!
ASK ANY MEDICAL REPRESENTATIVE ABOUT THE TRIPLE SULFA PRODUCTS HIS COMPANY OFFERS!

Cyanamid Fine Chemicals

AMERICAN Cyanamid COMPANY Fine Chemicals Division, 30 Rockefeller Plaza, New York 20, N. Y.

Another Lederle "First"!

MUMPS VACCINE

A practical immunizing antigen for prevention of mumps in children or adults where indicated.
Immunizes for about one year.
Packages: 2 cc. vial (1 immunization),
10 cc. vial (5 immunizations).

LEDERLE LABORATORIES DIVISION
AMERICAN Cyanamid COMPANY
PEARL RIVER, NEW YORK

Lederle

Mercy Hospital Institute of Radiation Therapy

The Henry Schmitz Medical Group

For Appointment
Victory 2-4700, Ext. 170 or RAndolph 6-4444

Herbert E. Schmitz, M.D., *Director*
Peter A. Nelson, M.D., *General Oncology*
Henry L. Schmitz, M.D., *Internal Medicine*
Janet Towne, M.D., *Gynecology*
Robert L. Schmitz, M.D., *General Surgery*
John F. Sheehan, M.D., *Pathologist*
Charles J. Smith, M.D., *Gynecology*
Charles S. Gilbert, M.D., *Internal Medicine*
William F. Cernock, M.D., *Internal Medicine*
Fred W. Eims, *Physicist*
Miss Hilda Waterson, R.N.
Helen Hansen, *Social Service*

COMPLETE TUMOR THERAPY
Including
SUPERFICIAL X-RAY THERAPY
DEEP X-RAY THERAPY up to 1,000 K.V.
RADIUM THERAPY

Daily Consultation at Institute
Tumor Clinic—Mercy Free Dispensary—Tuesday at 9 a. m.
Tumor Conference — J. B. Murphy Auditorium — Friday at 1 p. m.

Tuberculosis (Continued)

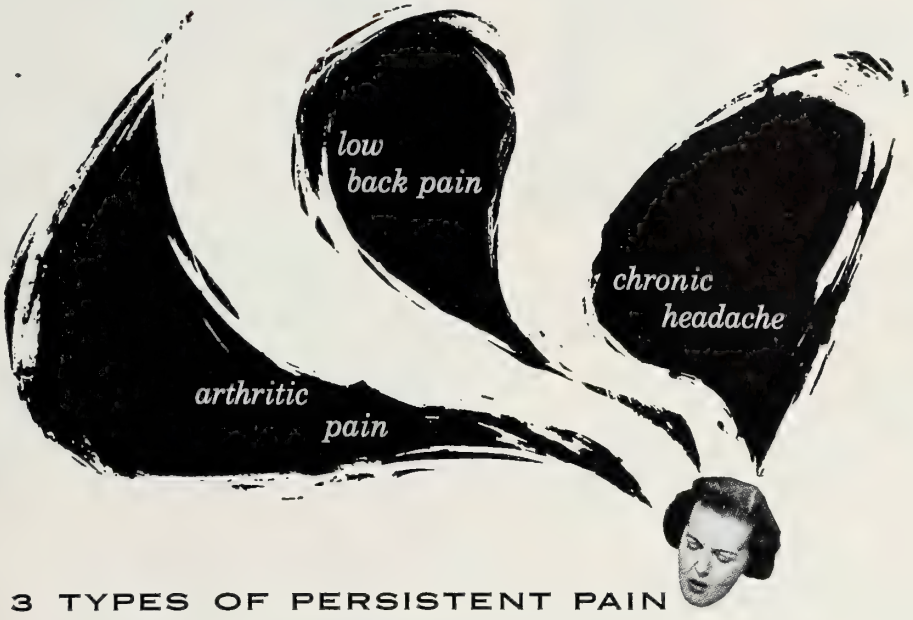
not be discounted, especially in early cases.

Obviously, there is need for more information, particularly of statistically significant numbers of patients treated in various fashions and followed for a considerable number of years. This form of tuberculosis is sufficiently important that its special problems merit particular study, and sufficiently prevalent that such study is practicable. *Prepared for the Committee on Therapy,* American Trudeau Society, by Carl Muschenheim, M.D., New York Hospital-Cornell Medical Center.

Control of morning Nausea

Dexamyl® (a light green, creased, heart-shaped tablet) was administered with 10 grains of sodium bicarbonate (a light green, unscored tablet) to 86 women during the first trimester of pregnancy. The first medicament invigorated the patient without nervous excitation, decreased appetite, and allayed depression. The second served solely as a placebo.

All of the 86 women complained of nausea either in the early morning or during the course of the day when meals were served. Each was given both tablets simultaneously 30 minutes before meals. Of the 86 patients treated, 78, or 90 percent, were entirely relieved of symptoms. Five were improved and three were unrelieved. Dexamyl was then withdrawn for seven days, but the sodium bicarbonate placebo was continued. Nausea or vomiting reappeared in 74 of the 86 patients. Dexamyl was again administered to the 74 women who were nauseated, and the placebo was withheld. Sixty-eight of them again became asympotamatic in three days, and six were relieved. The entire group of 86 showed marked improvement at the end of 10 days when both the placebo and Dexamyl were again prescribed. Continuation of this therapy for 80 days resulted in complete absence of symptoms in 74 of the 86 patients, partial relief in 10, and little or no benefit in two of the patients under observation. *Paul E. Craig, M.D. Use of An Anorexic Antidepressant In The Control Of Nausea and Vomiting of Pregnancy. J. Oklahoma M.A. Feb.* 1955.



3 TYPES OF PERSISTENT PAIN

with psychic side effects

As the conditions that cause these types of pain persist, the patient becomes more and more preoccupied with his pain. The depression, nervous tension and anxiety that nearly always accompany such pain combine to intensify and prolong it.

'Daprisal' relieves these psychic aspects of pain because it provides the mood-ameliorating effect of Dexamyl* (Dexedrine† and amobarbital). It brings about a feeling of energy and well-being, and restores optimism.

'Daprisal' works to relieve the pain itself because it provides the combined analgesic effect of acetylsalicylic acid and phenacetin, *potentiated* by amobarbital.

DAPRISAL*

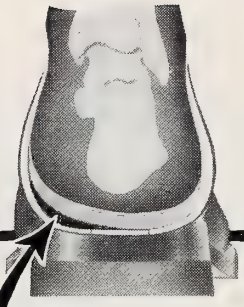
for the relief of pain and psychic side effects of pain

Smith, Kline & French Laboratories, Philadelphia 1

FORMULA: Each 'Daprisal' tablet contains 'Dexedrine' Sulfate (dextro-amphetamine sulfate, S.K.F.), 5 mg.; amobarbital, ½ gr. (32 mg.); acetylsalicylic acid, 2½ gr. (0.16 Gm.); phenacetin, 2½ gr. (0.16 Gm.).

*T.M. Reg. U.S. Pat. Off.
†T.M. Reg. U.S. Pat. Off. for dextro-amphetamine sulfate, S.K.F.

Foot-so-Port Shoe Construction and its Relation to Weight Distribution



- Insole extension and wedge at inner corner of heel where support is most needed.
- Special Supreme rubber heels are longer than most anatomic heels and maintain the appearance of normal shoes.
- The patented arch support construction is guaranteed not to break down.
- Innersoles are guaranteed not to crack, curl, or collapse. Insulated by a special layer of Texon which also cushions firmly and uniformly.
- Foot-so-Port lasts were designed and the shoe construction engineered with orthopedic advice.
- Over nine million pairs of men's, women's and children's Foot-so-Port Shoes have been sold.
- By a special process, using plastic positive casts of feet, we make more custom shoes for polio, club feet and all types of abnormal feet than any other manufacturer.

Write for details or contact your local **FOOT-SO-PORT** *Shoe Agency. Refer to your Classified Directory*

Foot-so-Port Shoe Company, Oconomowoc, Wis.

STOP

DIAPER RASH!

Diasof Helps Baby Two Ways



In liquid form . . . for easy use in washing machine or by hand rinse.

1. Contains a quarternary ammonium compound, as described in "The Treatment of Ammonia Dermatitis" in the Journal of Pediatrics, Jan., 1949, which eliminates bacteria causing ammonia dermatitis.
2. Diasof is not only a therapeutic for diaper rash, but also a prophylaxis if used in the last rinse each time diapers are washed. Diasof also contains a cotton softener, making the diapers velvet soft.

ELIMINATES NUISANCE CALLS

SAMPLES ON REQUEST

diasof

CAL PRODUCTS • 2132 Sacramento St.
Los Angeles, California

Travel and immunization

Persons planning cruises, including world cruises, touching yellow fever infected countries, Trinidad, Venezuela, Columbia, and Honduras, are reminded by the Division of Foreign Quarantine of the Public Health Service, of the necessity of possessing a valid yellow fever certificate. A valid certificate will be required at the next port of call from anyone who has touched any of these countries. In addition, anyone expecting to stay in any part of Central America should have a yellow fever vaccination for his own protection. The yellow fever vaccination requirements are presently being strictly enforced in all Caribbean area ports on account of the appearance of yellow fever in many places where it had not been heard of for over 20 years. They are also strictly enforced by the Union of South Africa, Egypt, India, and Pakistan.

Travelers coming directly from the United States can enter some, but not all, yellow fever infected areas without presenting a yellow fever vaccination certificate, but usually they cannot leave again without receiving yellow fever vaccination. Presentation of a valid certificate is compulsory for depature from Trinidad and Columbia, and probably also from certain ports of Venezuela. A yellow fever vaccination certificate does not become valid until 10 days after vaccination (in India and Pakistan, after 12 days). The certificate is valid for six years except in Curacoa, Aruba, and other Dutch possessions, where it is valid for only four years. *Immunization Information for International Travel. Pub. Health Rep., Dec.* 1954.

‹ ›

Tonic doses of digitalis

A practice which we have encountered is the use of "tonic" doses of digitalis in people complaining of weakness or fatigue. These people are often told that they have a tired heart. Careful evaluation reveals no evidence of cardiovascular illness and this use of digitalis is to be discouraged as it is totally lacking in therapeutic value. *Ralph M. Denham, M.D. Digitalis Therapy and Digitalis Intoxication. J. Kentucky M.A. March* 1955

the

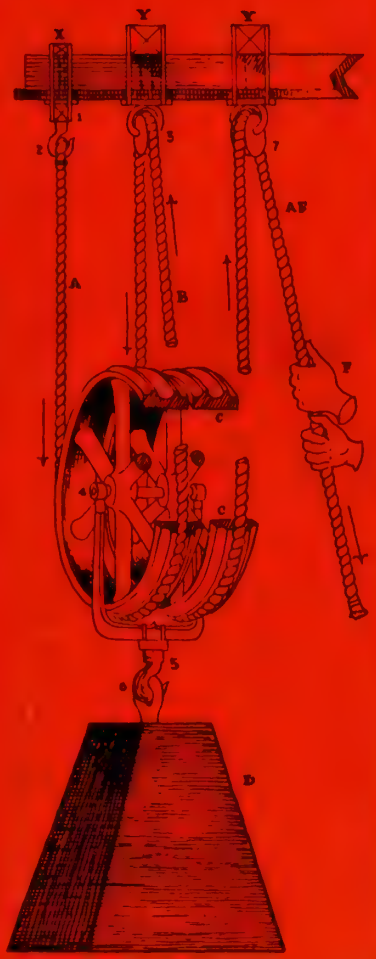
new

antiarthritic

with

multiple

advantages



Salicylates and cortisone have complementary action when combined . . .

Smaller doses of each are sufficient to produce a therapeutic response equivalent to massive cortisone therapy. With smaller doses, side effects are absent, thus permitting SALCORT therapy over a prolonged period. THERE ARE NO WITHDRAWAL PROBLEMS WITH SALCORT.

Salcort provides safe, dependable relief in arthritic affections. Early functional improvement and a sense of well being are significant in a large percentage of patients.

Each tablet contains:

Cortisone Acetate	2.5 mg.
Sodium Salicylate	0.3 Gm.
Aluminum Hydroxide Gel, dried	0.12 Gm.
Calcium Ascorbate (equivalent to 50 mg. ascorbic acid)	60 mg.
Calcium Carbonate	60 mg.

professional literature and sample available on request

THE S. E. MASSENGILL COMPANY

BRISTOL, TENNESSEE

SALCORT

Cancer research

A vast amount of money has been spent in the last ten years for the control of cancer. Some doubt that the returns have justified the expense. Yet these years have not been years of stagnation. In the clinical management of the disease, hormonal treatment has been developed for some forms, and antimetabolites and several chemical compounds have been successful in retarding the course of leukemia. The effects of virus inoculations have been studied, and many other substances have been tried which cannot yet be judged. A mass of data has been accumulated in the laboratory but it may be years before its value in controlling cancer in man will be known. Far from being discouraged and ready to give up or wait, we must recognize the enormity of the task, and be ready to redouble our efforts. We are only beginning to know how much more we need to know. *Thelma Brumfield Dunn, M.D. Morphology and a Cure for Cancer. J. Am. M. Women's A. April* 1955.

Boston Clinical Meeting

All persons who desire a place on the lecture program at the Boston Clinical Meeting of the American Medical Association November 29 — December 2, 1955, are urged to communicate immediately with the Chairman of the Program Committee — Theodore L. Badger, M.D., c/o Massachusetts Medical Society, 22 The Fenway, Boston 15.

Applications for space in the Scientific Exhibit are now available and will be sent on request. Exhibits will supplement the lectures as far as possible, and should portray subjects of a broad general interest. Requests for applications should be sent to the Secretary, Council on Scientific Assembly, American Medical Association, 535 N. Dearborn St., Chicago 10, Illinois.

‹ ›

To save something each month develops self control. This power frees one from fear and gives abiding courage. *Samuel Reyburn*

Lederle

FOLBESYN*

Vitamins *Lederle*

A well-balanced, high-potency vitamin formula containing B-Complex and C

FOLBESYN provides B-Complex factors (including folic acid and B_{12}) and ascorbic acid in a well balanced formula. It does not contain excessive amounts of any one factor.

FOLBESYN Parenteral may be administered intramuscularly, or it may be added to various hospital intravenous solutions. It is useful for preoperative and postoperative treatment and during convalescence.

Dosage: 2 cc. daily. Each 2 cc. provides:

Thiamine HCl (B_1)	10 mg.
Sodium Pantothenate	10 mg.
Niacinamide	50 mg.
Riboflavin (B_2)	10 mg.
Pyridoxine HCl (B_6)	5 mg.
Ascorbic Acid (C)	300 mg.
Vitamin B_{12}	15 micrograms
Folic Acid	3 mg.

FOLBESYN is also available in tablet form, ideal for supplementing the parenteral dose.

LEDERLE LABORATORIES DIVISION AMERICAN Cyanamid COMPANY Pearl River, New York

*REG. U.S. PAT. OFF.

for happy travel



BONAMINE* HCl

Brand of meclizine hydrochloride

chewing tablets

the NEWEST prescription for travel freedom from motion sickness

BONAMINE CHEWING TABLETS—the *only* motion-sickness medication which

(1) is pleasantly mint flavored, acceptable to children and adults who dislike taking pills
(2) is rapidly effective (most of the medication is extracted by 5 minutes of chewing)
(3) requires no water for administration
(4) promotes salivation and maintains the normal downward gastrointestinal gradient.

Well-tolerated BONAMINE is uniquely effective in a single daily dose. Notably free from side reactions.

BONAMINE medication is also indicated for the control of vertigo associated with vestibular and labyrinthine disturbances, cerebral arteriosclerosis, radiation therapy, Menière's syndrome and fenestration procedures.

BONAMINE CHEWING TABLETS contain 25 mg. of Bonamine each and are supplied in packets of 8, individually wrapped.

Also supplied as BONAMINE TABLETS of 25 mg. each, scored and tasteless, in boxes of 8 and bottles of 100 and 500.

*Trademark

Pfizer

PFIZER LABORATORIES, Brooklyn 6, N. Y.
Division, Chas. Pfizer & Co., Inc.

What the pathologist wants?

Tonsils, adenoids, foreskins, hernial sacs, and a dozen or more other assorted tissues removed by the surgeons do not have to be sectioned and examined microscopically, as a routine procedure. In fact, microscopic examination of each of a long list of tissues must be carried out only in rare instances. It is a matter of record that the Joint Commission for the Accreditation of Hospitals believes only that every single piece of tissue removed at operation should be sent to the laboratory. The Commission has never said, so far as we know, that every piece of tissue must be sectioned, but believes that the hospital's staff should adjudicate this question and formulate its own rules in this matter. The Commission states that the pathologist should acknowledge each and every piece of tissue in such a way as to legally protect the hospital, but that is the case of a considerable list of tissues, microscopic examination need be made only at the discretion of the pathologist. A list furnished by the Joint Commission contains 25 tissues and objects that fall into the category under discussion. *Editorial. To Section or Not to Section. Nebraska M. J. March* 1955.

‹ ›

G. C. rides again

The apparently prevalent opinion that gonorrhea is a disappearing disease cannot be supported with facts Last year there were nearly 250,000 cases reported in the United States. In Wisconsin, nearly 1,000 cases were reported and throughout the country there is an indication that this infection is on the increase. When we consider that there is poor reporting of the disease, it would seem likely that the total number of cases is much higher than the reported incidence, And, further, since the diagnosis of gonorrhea has not been greatly improved in recent years, it is not unlikely that many cases are not recognized, particularly chronic cases. The smear technic is fairly reliable in cases of urethritis in men, but in chronic cases it loses much of its reliability; and it is entirely unreliable in women, particularly in chronic cases. *Editorial. Prevention of Gonorrheal Ophthalmia. Wisconsin M.J. Feb.* 1955.

Back to first principles for REAL BREAD

The makers of Pepperidge Farm Bread believe in fresh natural ingredients for nutritionally valuable and taste-pleasing bread.

So the flour for our Whole Wheat Bread is stone-ground in our own grist mills—contains the wheat germ and all the natural goodness of the whole grain. And we use whole milk, sweet cream butter, yeast and unsulphured molasses to make our bread.

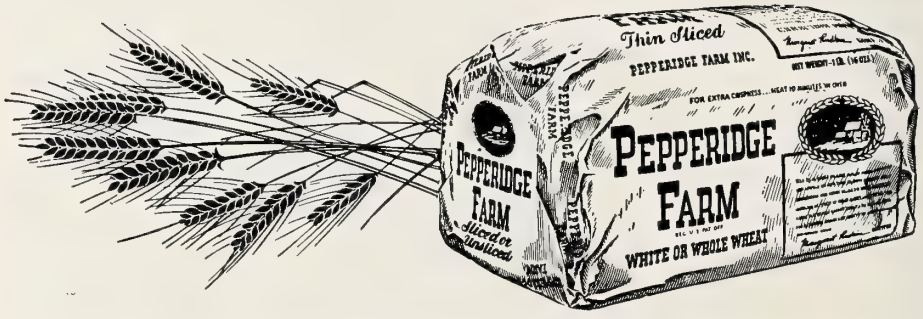
We offer White Bread, too—made with *unbleached* flour, dairy-fresh ingredients.

We suggest that Pepperidge Farm Bread deserves a place on your table.

For information about our special SALT-FREE Bread, please write to me.

Margaret Rudkin

DIRECTOR



PEPPERIDGE FARM BREAD

NORWALK, CONNECTICUT



portrait of a contented baby

fibrefree HYPOALLERGENIC FORMULA

1. *An ideal food for milk allergies, eczema and problem feeding*
2. *An excellent formula for regular infant feeding*

Strikingly similar to mother's milk in composition and ease of assimilation, babies thrive on SOYALAC.

Clinical data furnish evidence of SOYALAC'S value in promoting growth and development.

Protein of high biologic value is obtained from the soybean by an exclusive process.

SOYALAC is an ideal "regular" formula. It also helps solve the feeding problems of prematures and infants requiring milk-free diets.

No mixing problem with SOYALAC Concentrated Liquid. Simply dilute with equal amount of water.



FREE BOOKLET AND SAMPLES

A request on your professional letterhead or prescription form will bring complete information and a supply of samples. Address Loma Linda Food Company, Arlington, California or Mount Vernon, Ohio.

LOMA LINDA FOOD COMPANY | *Medical Products Division*

ARLINGTON, CALIF. MOUNT VERNON, OHIO

FAIRVIEW
Sanitarium

DEVOTED TO THE ACTIVE TREATMENT OF

MENTAL and NERVOUS DISORDERS

Specializing in Psycho-Therapy, and Physiological therapies including:

- **Electro-Shock**
- **Electro-Narcosis**
- **Insulin Shock**
- **Carbon Dioxide Therapy**

Out Patient Shock Therapy Available

ALCOHOLISM Treated by Comprehensive Medical-Psychiatric Methods.

2828 S. PRAIRIE AVENUE, CHICAGO 16 J. DENNIS FREUND, M. D., Medical Director

Phone Victory 2-1650 **Registered by the American Medical Assn.**

The origin of obesity

Obesity undoubtedly has been with us not longer than the time when man took up a sedentary type of living. It is very unlikely that when he was a nomad or given to the chase to get his food, that obesity could have existed to any extent. When he began "living in the land of the sown" and food was available in greater regularity for the most part, then activity was more restricted. It was then the incidence of obesity increased. In primitive communities, the cost of a wife was directly in proportion to her weight. In one area in which the writer was, the average cost of a wife who was lean and dehydrated was $10.00 and the top price of the daughter of the sheik who had large flocks and who could be well nourished, would go up to $40. *Louis Krause, M.D. Obesity. Maryland M.J. Feb.* 1955.

‹ ›

Treatment for advanced cancer

In an effort to develop a new approach to the definitive palliation of patients with advanced cancer, 100 cases were treated with large doses of ACTH or cortisone administered simultaneously with nitrogen mustard. The majority of the 100 patients were in advanced or terminal phases of cancer and had failed to respond successfully to previous surgical, radiation, or hormone therapy. Unusual temporary remissions for intervals as long as three years were obtained in 16 per cent of patients, often with associated tumor regression or arrest. An additional 15 per cent received good palliation, with prolongation of life in increased comfort. The remaining 69 patients were classed as fair (29 per cent) or poor (40 per cent) in palliative response and received little or no benefit. *William D. McCarthy, M.D. The Palliation and Remission of Cancer with Combined Corticosteroid and Nitrogen Mustard Therapy. New England J. Med. March* 24, 1955.

‹ ›

It is important to emphasize in public health practice that the control of bovine tuberculosis is also dependent on the prevention of contact between noninfected animals and persons with open infections. James H. Steele, D.V.M., M.P.H., Pub. Health Rep., Nov., 1954.

in whooping cough

ELIXIR BROMAURATE

GIVES EXCELLENT RESULTS

Cuts short the period of illness and relieves the distressing spasmodic cough. Also valuable in Bronchitis and Bronchial Asthma.

In four-ounce original bottles. A teaspoonful every 3 to 4 hours

Prescribed by Thousands of Doctors

GOLD PHARMACAL CO. **NEW YORK CITY**









Which glove works best in surgery?

Please pardon us if we seem facetious, but a surgical glove seems a good illustration of the importance of appropriate design in the manufacture of accessories. Without this glove surgery wouldn't be safe. And only when it serves as intended, by such as permitting complete finger freedom and sensitivity, is it of any value. When so designed it has no equal for its purpose.



AND so it is with accessories of other kinds. Those for example you need to run your electrocardiograph. The accuracy and usefulness of such a precision instrument is in direct ratio to the effectiveness of its parts *and accessories.* Of what value is the high deflection speed and top performance of an ECG if the recording paper cannot successfully show it in clear, sharp and distinct registrations? Of what value is an electrode paste which does not reduce patient resistance at electrode connections to a level suitable for modern cardiography?

An accessory designed by the maker of an instrument should receive the same care, study and research as any of the important parts or components of that instrument. This is true in regard to the Viso-Cardiette. Much of the Sanborn Viso-Cardiette's fame as a direct-writing cardiograph can be attributed to the continuous, painstaking research on the two accessories which were *originally designed* by Sanborn Company, and which are so necessary to the Viso's accuracy—Permapaper (inkless recording paper) and Redux (electrode paste).



Permapaper and Redux are major examples of Sanborn accessories that receive diligent surveillance as to the service they are performing — one more part of the Sanborn policy of complete service to the ECG user.

SANBORN COMPANY

CHICAGO *Branch Office*
122 S. Michigan Ave., *Phone: Wabash 2-0665*

The NORBURY SANATORIUM

JACKSONVILLE, ILLINOIS — INCORPORATED and LICENSED

For the Treatment of Nervous and Mental Disorders

FRANK GARM NORBURY, M.D., Medical Director
HENRY A. DOLLEAR, M.D., Superintendent
FRANK B. NORBURY, M.D., Associate Physician

Address Communications — THE NORBURY SANATORIUM, Jacksonville, Illinois

Health insurance

We have suggested heretofore that there is in our society, and probably always will be, a segment that are not now and never will be insurable. Their status, insurance-wise, reflects the fact that they are public charges not only in the matter of health care but likewise for the necessities of food, shelter, and clothing. It should be apparent that any attempt to include the indigent among those insured would be but an inefficient and more expensive substitute for direct assistance. It is true that there are many of our countrymen who become indigent at the time of a disability and who, through education, could be encouraged to place a higher personal priority of desirability on voluntary insurance than they do at the present time. This means simply that we have a selling job to do in the encouragement of these people to lay aside the few dollars per month needed for adequate insurance rather than spending for consumers' goods which, from at least a social standpoint, are less important than protection. *Edwin J. Faulkner. Present Role of Voluntary Health Insurance. Texas J. Med. March* 1955.

A $100,000 verdict

Verdicts in much larger amounts are now being made in the courts than was the practice several years ago. Consequently, it behooves every physician to review his insurance coverage and be sure he is adequately protected from financial loss. *Roland Hammond, M.D. The Committee on Medical Defense and Grievance. Rhode Island M.J. March* 1955.

‹ ›

New laws for tuberculosis control

Legislative action is needed to strengthen the laws for tuberculosis control. This is especially true for the small percentage of recalcitrant patients who carelessly spread their disease to others. The positive sputum case in the community who refuses treatment and carelessly contaminates others needs to be isolated from the community. At first, all attempts should be made to secure the patient's co-operation by education but should this fail, stronger measures are needed. Public opinion must rally behind this effort if it is to succeed. *William Newcomer, M.D. and Elmer P. Sauer, M.D. The Problem before us in Tuberculosis. Maryland M.J. March* 1955.

North Shore Health Resort

on the shores of Lake Michigan
WINNETKA, ILLINOIS
NERVOUS and MENTAL DISORDERS
ALCOHOLISM and DRUG ADDICTION
Modern Methods of Treatment
MODERATE RATES

Established 1901 — *Fully Approved by the*
Licensed by State of Illinois — *American College of Surgeons*

SAMUEL LIEBMAN, M.S., M.D.
Medical Director

225 Sheridan Road — Winnetka 6-0211

CARDIAC EDEMA
GLAUCOMA
EPILEPSY

now benefited by

Diamox*

Acetazolamide Lederle

DIAMOX has proved to be a very effective, safe, and convenient oral diuretic for use in controlling cardiac edema. In fact, it is now the most widely prescribed drug of its type. Recent evidence shows it is useful in two other important ways:

IN EPILEPSY

DIAMOX suppresses both the frequency and the severity of seizures, without apparent direct sedative action. DIAMOX appears to produce a relative acidosis in a manner similar to the ketogenic diet, and may also have a direct effect on nerve tissue. (1)

IN ACUTE GLAUCOMA

significant reduction in intraocular pressure is produced by oral administration of DIAMOX. This probably results from a decrease in the secretion of aqueous humor. DIAMOX also appears to enhance the action of commonly employed miotics. (2)

One product . . . three uses . . . a versatile therapeutic agent!

Available in 250 mg. tablets for oral use
and 500 mg. ampuls for intravenous use.

1. Merlis, S.: DIAMOX: A Carbonic Anhydrase Inhibitor—Its Use in Epilepsy. Neurology. 4:11, 863-866 November 1954.

2. Becker, B.: Decrease in Intraocular Pressure in Man by a Carbonic Anhydrase Inhibitor, DIAMOX. Am. J. Ophth. 37:1, 13-15 January 1954.

*REG. U.S. PAT. OFF.

Lederle LEDERLE LABORATORIES DIVISION AMERICAN Cyanamid COMPANY PEARL RIVER, NEW YORK

THE
MEDICAL PROTECTIVE
COMPANY
FORT WAYNE, INDIANA

the doctor's most secure source of security

PROFESSIONAL PROTECTION
EXCLUSIVELY
SINCE 1899

CHICAGO Office:
T. J. Hoehn, E. M. Breier and
W. R. Clouston, Representatives,
1142-44 Marshall Field Annex Building,
Telephone State 2-0990

SPRINGFIELD Office:
F. A. Seeman, Representative,
Telephone Springfield 4-2251

Too many journals

Publishers have not been slow to respond to the need for journals. There were 5,000 within the first 30 years of medical journalism, and today the proliferation of medical journals has become almost a malignant process which has been described by the term, journalistic blastoma. For the seeker after knowledge, the cumulative quarterly index has become as important as the telephone directory, and even with its help there is still a great danger that medical pearls of great price are being cast before regular subscribers but remain hidden from those requiring them to complete their necklaces of knowledge. *John Lister, M.D. By the London Post. New England J. Med. March* 31, 1955.

We must translate health into the attitudes and behavior patterns of the many if we are to have clean and healthy communities. Henry F. Vaughan, Dr. P.H. Am. J. Pub. Health, Mar., 1955.



Ideal practice requires periodic adaptation of the *individualized* formula to the growing infant





Karo Syrup . . . a carbohydrate of choice in "milk modification" for 3 generations

With Karo, milk and water in the universal prescription, the doctor can readily quantitate the best formula for each infant. Individual infant feeding assures early adaptation of the most satisfactory milk mixture. A successful infant formula thus *lays the foundation* for early introduction of semi-solid foods.

Karo is well tolerated, easily digested, gradually absorbed at spaced intervals and completely utilized. It is a balanced fluid mixture of maltose, dextrins and dextrose readily soluble in fluid whole or evaporated milk. *Precludes* fermentation and irritation. Produces no intestinal reactions. Is hypoallergenic. Bacteria-free Karo is safe for feeding prematures, newborns, and infants—well and sick.

Light and dark Karo are interchangeable in formulas; both yield 60 calories per tablespoon.

Behind each bottle three generations of world literature.

CORN PRODUCTS REFINING COMPANY
17 Battery Place, New York 4, N. Y.

BELLEVUE PLACE

For
NERVOUS and MENTAL DISEASES

★

Edward Ross, M.D., Medical Director
BATAVIA ILLINOIS
PHONE BATAVIA 1520



LINCOLNVIEW
Hospital and Sanitarium
Springfield, Illinois
8th & Capitol

Albert P. Ludin, M. D., Medical Director

MENTAL-ALCOHOLIC-ADDICTED

Rapid Intensive Treatment

Registered A.M.A. Licensed State of Illinois

Phone 2-3303

Fisherman's prayer

God grant that I may live to fish to my dying day.
And when it comes to my last cast, I then most humbly pray,
when in the Lord's safe landing net I'm peacefully asleep,
that in his mercy I be judged good enough to keep.

Author Unknown

‹ ›

It seems probable that one of the real values of tuberculosis case detection through chest x-ray surveys is a saving in lives as the result of treatment early in the course of the disease. This value is in addition to the prevention of spread of infection to others that must have occurred as the result of the discovery and isolation of infectious tuberculosis before it ordinarily would have been brought to light. Robert J. Anderson, M.D., Philip E. Enterline, M.A., Frank J. Hill, M.D., and Jean Roberts, M.P.H., Pub. Health Rep., Nov., 1954.

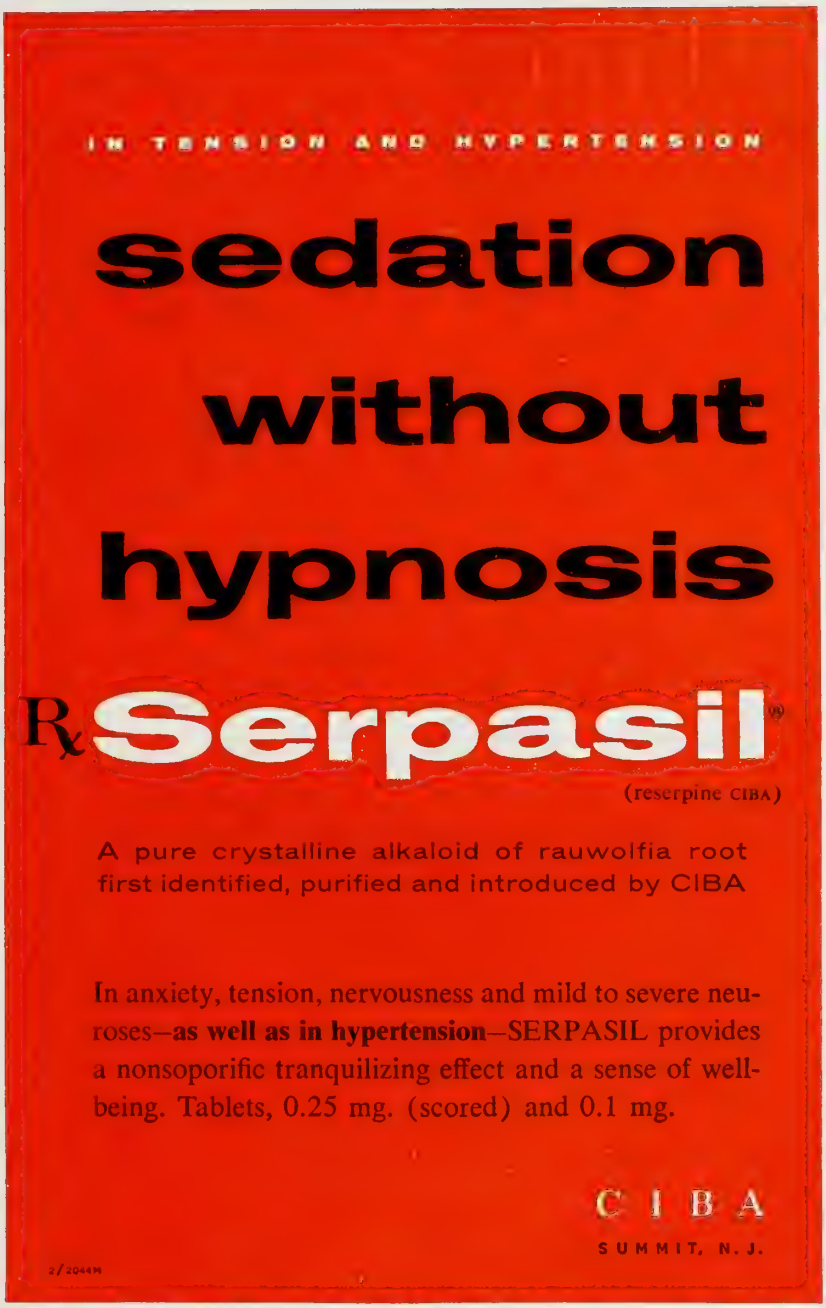
Relax the best way ... pause for Coke



Time out for refreshment

DRINK
Coca-Cola
REG. U.S. PAT. OFF.





New! SERPASIL® ELIXIR
Each 4-ml. teaspoonful contains 0.2 mg. of Serpasil



MARY POGUE SCHOOL, Inc.

Complete facilities for training retarded and epileptic children educationally and socially. Pupils per teacher strictly limited. Excellent educational, physical and occupational therapy programs.

Recreational facilities include riding, group games, selected movies under competent supervision.

Separate buildings for boys and girls under 24 hour supervision of skilled personnel.

Catalog on request

G. H. Marquardt, M.D. — *Medical Director*

Barclay J. MacGregor — *Registrar*

33 GENEVA ROAD, WHEATON, ILLINOIS

(near Chicago)

Classified Ads

RATES FOR CLASSIFIED ADVERTISEMENTS—For 30 words or less: 1 insertion, $3.00; 3 insertions, $8.00; 6 insertions, $14.00; 12 insertions, $24.00; from 30 to 50 words: 1 insertion, $4.00; 3 insertions, $10.50; 6 insertions, $20.00; 12 insertions, $30.00. Extra words: 1 insertion 10c each; 3 insertions, 25c each; 6 insertions, 40c each; 12 insertions, 50c each. A fee of 25c is charged for those advertisers who have answers sent care of the Journal. Cash in advance must accompany copy.

PSYCHIATRISTS — Wisconsin's Mental Hygiene program. Salary based on training, experience and level of treatment responsibility. Range $8230 to $11,500. Inquire Dr. Leslie A. Osborn, Director Division of Mental Hygiene, Madison . . . For staff positions in state diagnosis and treatment hospitals — Dr. Walter J. Urban, Superintendent, Mendota State Hospital, Madison or Dr. John T. Petersik, Superintendent, Winnebago State Hospital, Winnebago . . . Wisconsin license required. New legislation waives residence and citizenship requirements.

WANTED: Physician, 40-55, as staff member of active private sanitarium for diseases of addiction. Permanent, full-time, salaried position for qualified physician preferably with a background of general practice. Please apply by letter to James I. Oughton, administrator, The Keeley Institute, Dwight, Ill. 7/55

FOR SALE: Spencer microtome complete with freezing attachment. Price $175.00. Call Central 6-1565 or Mansfield 6-2388. 9/55

THUMBSUCKING

since infancy caused this malocclusion.



THUM TRADE MARK

THUM broke the habit and teeth returned to normal position.

ACCEPTED FOR ADVERTISING IN PUBLICATIONS OF THE AMERICAN MEDICAL ASSOCIATION

Get Thum at your druggist or surgical dealer. Prescribed by physicians for over 20 years.

Women physicians

A recent study by Birch, Galbraith, and Moon on 151 women who graduated from the University of Illinois during the period, 1921-1945, indicated that women physicians "practiced a lot of medicine and compare favorably statistic-wise with a comparable group of men." The major medical fields in which these women practice, listed according to the number in each area, are as follows: Psychiatry, pediatrics, internal medicine, anesthesia, dermatology, ophthalmology, surgery, pathology, and roentgenology. This order is in agreement with findings of past studies on the areas of specialization preferred by women. *Medical Education of Women Has Proved Worth While. J. Am. M. Women's A. March* 1955.

Diabetes on the increase

In 1950 diabetes mellitus caused the death of 24,419 persons (16.2 per 100,000 population), ranking tenth as a cause of death in continental United States. In 1951 there were 25,047 deaths from diabetes (ranking ninth); in 1952 there were 25,474 (ranking eighth); and, according to provisional figures there were an estimated 25,390 deaths in 1953 (ranking eighth). In addition to these persons dying from diabetes, a large number of persons with diabetes die from vascular degeneration and are classified in one or another of the categories of the cardiovascular-renal conditions. *Albert P. Iskrant M.A. and Arnold B. Kurlander, M.D. DIABETES MELLITUS MORTALITY IN THE CONTINENTAL U.S.*-1950. *J. Chron. Dis Apr.* 1955.

THE KEELEY INSTITUTE

DWIGHT, ILLINOIS

Treating alcoholism and other problems of addiction.

REGISTERED BY THE AMERICAN MEDICAL ASSOCIATION — MEMBER AMERICAN HOSPITAL ASSOCIATION.

The
Illinois Medical Journal

The Official Journal of

The Illinois State Medical Society



Index to Volume 108

July—December, 1955

Editor
Harold M. Camp
Monmouth, Illinois

Associate Editor
Theodore Van Dellen
Chicago, Illinois

Business Manager and Managing Editor
Mr. L. E. Malley
185 N. Wabash Avenue
Chicago 1, Illinois

Business Office
185 N. Wabash Avenue
Chicago 1, Illinois

Editorial Office
Medical Arts Building
Monmouth, Illinois

ILLINOIS STATE MEDICAL SOCIETY OFFICERS — 1955-1956

President: F. Garm Norbury, 1631 Mound Avenue, Jacksonville
President-Elect: F. Lee Stone, 30 N. Michigan Ave., Chicago
1st Vice-President: C. Elliott Bell, 250 N. Water St., Decatur
2nd Vice-President: Maurice M. Hoeltgen, 1607 W. 51st St., Chicago
Secretary-Treasurer: Harold M. Camp, 224 S. Main Street, Monmouth

COUNCILORS

District		Term Expires
1	Carl E. Clark, Sycamore	1956
2	Joseph T. O'Neill, 628 Columbus St., Ottawa	1956
3	Earl H. Blair, 6240 S. Kedzie Ave., Chicago	1957
3	E. A. Piszczek, 6410 N. Leona Ave., Chicago	1956
3	Raleigh C. Oldfield, 715 Lake St., Oak Park	1957
3	John Lester Reichert, 1791 Howard St., Chicago	1958
3	H. Close Hesseltine, 5841 S. Maryland Ave., Chicago	1958
3	Caesar Portes, 25 E. Washington St., Chicago	1956
4	Charles P. Blair, 102 S. First St., Monmouth	1958
5	Jacob E. Reisch, 500 S. Fifth St., Springfield	1958
6	Warner H. Newcomb, 316 W. State St., Jacksonville	1957
7	Arthur F. Goodyear, 142 E. Prairie Ave., Decatur	1958
8	Harlan English, 139 N. Vermilion St., Danville	1958
9	Burtis E. Montgomery, Harrisburg	1957
10	Willard W. Fullerton, 101 S. Market St., Sparta	1957
11	Edwin S. Hamilton, 189 S. Schuyler Ave., Kankakee	1956

Councilor at Large — Arkell M. Vaughn, 1180 East 63rd St., Chicago
Chairman of the Council — Joseph T. O'Neill

ILLINOIS MEDICAL JOURNAL

JOURNAL COMMITTEE—Jacob E. Reisch, Chairman, Joseph T. O'Neill, Albert VanderKloot, John Lester Reichert, Paul P. Youngberg, R. C. Oldfield.
EDITORIAL BOARD—James H. Hutton, Chairman, John R. Wolff, Frederick H. Falls, Edward F. Webb, Arkell M. Vaughn, Edwin F. Hirsch, Samuel A. Levinson, John T. Reynolds, Clark W. Finnerud, Francis L. Lederer, Ralph C. Aiken, Mary Karp, Francis J. Gerty, Jacob E. Reisch.

MEDICAL SERVICE & PUBLIC RELATIONS

Percy E. Hopkins, Chairman.....800 W. 78th St., Chicago

MEDICO-LEGAL COMMITTEE

George C. Turner, Chairman..670 N. Michigan Ave., Chicago

MEDICAL TESTIMONY COMMITTEE

Oscar Hawkinson, Chairman.....1011 Lake St., Oak Park

PERMANENT COMMITTEE ON ARCHIVES

Tom Kirkwood, Chairman.....Lawrenceville
J. J. Moore, Secy., 55 E. Washington St.....Chicago
E. H. Weld.....Rockford

EDUCATIONAL COMMITTEE

Charles P. Blair, Chairman.....Monmouth
Karl L. Vehe, Co-Chairman...7001 N. Clark St., Chicago 26
Ann Fox, Secretary.....185 N. Wabash Ave., Chicago 1

SCIENTIFIC SERVICE COMMITTEE

Louis R. Limarzi, Chairman..185 N. Wabash Ave., Chicago 1

POST GRADUATE COMMITTEE

Louis R. Limarzi, Chairman.185 N. Wabash Ave., Chicago 1
George E. Kirby, Co-chairman.....Spring Valley

GENERAL COUNSEL

Mr. John W. Neal.....707 S. Wood St., Chicago
Assoc Counsel, Mr. W. L. Oblinger, Reisch Bldg., Springfield

SECTION OFFICERS, 1956-1957

ALLERGY:

Chairman: Milton M. Mosko, 55 East Washington Street, Chicago
Secretary: Leonard Harris, 331 Fulton St., Peoria

ANESTHESIOLOGY:

Chairman: Arthur T. Shima, 532 N. Oak Park Ave., Oak Park
Secretary: E. M. Dewhirst, 607 North Logan Avenue, Danville
Alternate: Mary Karp, 250 East Superior Street, Chicago

CARDIOVASCULAR DISEASE:

Chairman: Chauncey C. Maher, 6 North Michigan Ave., Chicago
Secretary: Emmet F. Pearson, 504 East Monroe St., Springfield

DERMATOLOLGY:

Chairman: James Herbert Mitchell, 25 E. Washington St., Chicago
Secretary: Malcolm Spencer, 605 North Logan Avenue, Danville

EYE EAR NOSE AND THROAT:

Chairman: Fletcher Austin, 720 North Michigan Ave., Chicago
Secretary: G. L. Porter, 602 West University Ave., Urbana

MEDICINE:

Chairman: Jacques M. Smith, 720 North Michigan Ave., Chicago
Secretary: Robert M. Hoyne, 602 West University Ave., Urbana

OBSTETRICS & GYNECOLOGY:

Chairman: Charles D. Krause, 1700 West 87th Street, Chicago
Secretary: Carl Greenstein, 207 W. University Ave., Champaign

PATHOLOGY:

Chairman: Jerry J. Kearns, 3432 West Jackson Blvd., Chicago
Secretary: Frederick Bauer, 1439 S. Michigan Ave., Chicago

PEDIATRICS:

Chairman: J. Keller Mack, 614 South 7th Street, Springfield
Secretary: Noel G. Shaw, 636 Church Street, Evanston

PREVENTIVE MEDICINE & PUBLIC HEALTH:

Chairman: Fred Long, 419 Fulton St., Peoria
Secretary: Herbert Ratner, 129 Lake Street, Oak Park

RADIOLOGY:

Chairman: Fred H. Decker, Methodist Hospital, Peoria
Secretary: Hildegarde A. Schorsch, Cook County Hospital, 1825 W. Harrison St., Chicago

SURGERY:

Chairman: Cornelius M. Annan, 1180 East 63rd Street, Chicago
Secretary: David A. Bennett, Coleman Clinic, Canton

Index to Volume 108

Issue	*Pages*	*Issue*	*Pages*
July	1-94	October	213-256
August	95-166	November	257-314
September	167-212	December	315-368

This Index is Arranged Under the Following Headings: AUTHORS, CORRESPONDENCE, DEATHS, EDITORIALS, HOUSE OF DELEGATES, MEDICAL ECONOMICS, NEWS OF THE STATE, ORIGINAL ARTICLES

Authors

B

Baker, Wm. J., 238
Baran, Charles, 117
Binder, Morris, 321
Bledsoe, Alene, 220
Boshes, Louis D., 190

C

Colangelo, C., 223
Cummings, John R., 120

D

Derlacki, Eugene L., 1
Doswald, A. M., 278
Drennan, George L., 325
Drever, R. J., 117

F

Feinberg, Alan R., 5
Feinberg, Samuel M., 5
Feldman, L., 341
Fogelson, Samuel J., 182
Francis, Thomas, Jr., 257

G

Gillespie, James B., 327
Goldberg, Edwin E., 341

H

Hirsch, Edwin F., 128, 192, 238, 287, 345

I

Irons, Ernest E., 107

J

Jung, Frederic T., 355

K

Krause, Arlington C., 337
Kulis, John C., 280
Kulwin, Myron H., 179
Kurth, M. E., 117

L

Lackenbacher, Rudolph S., 14
Lewin, Philip, 190
Lichtenstein, M. R., 101

M

Mack, J. Keller, 185
Maxwell, Charles L., 269

N

Necheles, H., 275
Nechtow, Mitchel J., 278
Norbury, F. Garm, 226

O

Ochsner, Alton, 213

P

Paddock, Richard, 167
Pfister, Charles W., 283
Portes, Caesar, 301

R

Raber, Paul A., 171
Reich, Walter J., 278
Roth, Russell B., 261
Rothman, Stephen, 10
Rubenstein, M. William, 278
Rudman, Irving, 120, 175

S

Samet, Eli T., 182
Samuels, Thomas W., 236
Saphir, William, 280
Sbertoli, Maurice W., 321
Scannell, Margaret, 177
Schmitz, Herbert E., 177
Schulman, Leonard M., 218
Seagle, J. B., 231
Shair, Hilliard M., 228
Shrifter, Harold B., 341
Silverman, Frederic N., 95
Smith, Harold E., 273
Stenn, Frederick, 112, 113
Stern, Kurt, 315

T

Tatarowicz, B. J., 283
Thompson, Edward M., 330

W

Weyl, Ruth, 265
Winter, Irwin C., 334
Wolff, John R., 246
Wright, Glenn E., 286

Correspondence

Academy of Psychosomatic Medicine 201
Allergy, Officers of the Chicago Society of 205
A.M.A. Official Tour to Nassau 305
A.M.A. Sponsoring Three Regional Medical-Legal Conferences 202
American Congress of Physical Medicine and Rehabilitation, The 134
American Dermatological Association Annual Prize Essay Contest 203
American Goiter Association 306
Announcement of the Van Meter Prize Award 203
Annual Session of Illinois Chapter, Academy of General Practice 251
Army to Pay Higher Entrance Rates to Civilian Physicians 204
Atomic Warfare, Military Surgeons to Discuss Medical Aspects of 201
Blue Cross Increases Benefits and Membership Dues 305
Cancer Lecture Series 250
Cerebral Palsy Officers, American Academy for ..361
Chest Physicians Essay Contest 306
Child Psychiatry, Officers of Chicago Council of ..362
Clinics for Crippled Children Listed for—
August 22
September 134
October 200
November 250
December 307
January 360
Draft, New Changes and Procedures in the Doctor 200
Exhibit on Uterine Cancer Test Available 203
Financial Aid for Student Nurses 202
Fiske Fund Prize Dissertation, 1955 252
Hektoen Institute Awards 136
He Was There 133
Hospitals to be Published Twice Monthly 205
I.A.G.P. Postgraduate Program 205
Illinois Association of Medical Health Officers 22
Industrial Health P.G. Courses 251
Industrial Medicine, Fellowships in 306
Intestinal Research Institute 361
Medical Reservists to Earn Credit Points at Military Surgeons Meeting 252
Mississippi Valley Medical Society Meeting 136
Nuclear Medicine, Central Society of 362
Northwestern University Medical School in Radiation Physics 361
Northwestern University Medical School, New Appointments at 135
Obstetrics and Gynecology, American Board of ..361
Occupational Skin Problems, Instruction in 135
Officers of Illinois Medical Service Blue-Shield Plan 135
Ophthalmology and Otolaryngology, Midwinter Seminar in 360
Ophthalmology Journal, New 205
Pan American Medical Women's Alliance, Notice of V Congress of 361
Plastic Surgery of the Head and Neck, Second Graduate Course in 205
Physical Therapy Examination 307
Postgraduate Assembly of the Endocrine Society .133
Postgraduate Courses on Diseases of the Chest 136
Postgraduate Gastroenterology, Course in 135
Psychiatric Lecture Series for all Physicians 133
Rheumatic Diseases, Midwest Conference on 204
University of Michigan Medical School Postgraduate Conference 251

Deaths

Allen, Harvey S. 27
Albus, William Reuben 313
Auld, Frank Parkinson 313
Backer, Meyer 27
Berry, Frederick A. 367
Beschloss, Ottokar 140
Birmingham, Eugene E. 140
Birnbaum, Richard 27
Blaufuss, Armin L. 313
Boulton, Stanton S. 27
Bowser, Harold Curtis 313
Breakstone, Edgar O. 367
Burkhart, Victor H. 212
Cain, Cornelius R. 140
Carley, Paul Sterling 27
Castro, Parley Carper 140
Chittum, Jason D. 27
Cottrell, Thomas 27
Danielson, Wilford Aldrich 256
Davies, Raymond E. 27
Davidson, Herman P. 367
Deardorff, Frank Benson 212
Dent, John Harris 140
Deuterman, Joel L. 212, 313
Dickinson, Harry Barham 212
Dicus, George A. 27
Doerann, August Frederick 212
Donovan, Roscoe P. 313
Donovan, William P. 140
Edwards, Robert W. 256
Firfer, Bourke 367
Fitz, Frederick W. 313
Foster, Thomas J. 367
Frankenstein, Victor S. 140
Fuller, R. C. 27
Gaebler, Arthur 140
Gaff, John Henry 256
Gilborne, Henry B. 313
Glatter, Zoltan 212
Goldfine, Manuel 140
Greaves, Horatio Norman 313
Hambrecht, Frederick E. 140
Hastings, James Barnard 212
Haynes, Halbert A. 140
Henry, James Clayton 212
Hess, Julius H. 367
Hill, George Ray 256

Hines, Laurence E. 27
Hougland, Walter Louveria 367
Johnson, George Frederick 256
Kelly, Blair 313
Kelly, Raymond M. 212
Khamis, Joseph Abraham 313
King, Walter W. 27
Klaptoz, Adalbert 313
Klawans, Eugenia A. 368
Kramer, Gabriel B. 140
Lambert, Joseph S. 313
Leininger, Elmer C. 212
Lenz, Joseph A. 27
Lester, Harry S. 140
Levinson, Abraham 313
Leviton, Nathan David 313
Long, James U. 368
Lutton, Ethelbert A. 313
Maha, Frank J. 368
McCradie, Andrew R. 313
McCarthy, Ralph Rowland 368
McDonald, William Brown 256
Mendelsohn, Jacob J. 212
Miller, John Estill 27
Mitchell, William J. 212
Munson, Louis M. 140
Nassar, Naif E. 256
Noe, Philip R. 313
Opitz, John H. 368
Parker, James William 313
Parsons, Frederick H. B. 27
Perry, Benjamin 368
Perusse, George L. 212
Peterson, Carl Melancton 313
Pike, Charles H. 313
Poniatowski, Jerome Francis 140
Prescott, Harry V. 256
Puris, Abram Martin 212
Roberts, John Charles 256
Rosenberg, Harry 313
Rosenberg, William A. 368
Rosenblate, Adolph J. 368
Roth, Henry H. 27
Samuel, Jacob 313
Schiller, Alfred A. 27
Schipfer, Lloyd Albert 368
Senturia, Ben Druze 256
Shabat, Louis Willard 368
Sharkey, Mary Ellen 256
Sheerer, Walter Winfield 140
Shurtz, Richard Charles 313
Souders, John C. 313
Speed, Kellogg 140
Theobald, John J. 140
Vanatta, Clyde L. 140
Van Valkenburg, John Leroy 27
Vertuno, Louis Abbott 368
Waldman, Joseph Sterling 27
Weiner, Samuel Isaac 314
Weiss, Emil 27
Welch, Gilford N. 314
Westervelt, J. C. 368
White, James R. 212
Wiener, Samuel H. 140
Winn, John P. 27
Worden, George Kent 140

Editorials

Alien Physicians Studying in the United States ..243
A.M.A. Annual Meeting, The 19
A.M.A. Study Conference 349
Book Reviews, July 52a, Aug. 42a, Oct. 58a, Nov. 74a, Dec. 42a
Clinical Meeting of the A.M.A. 300
Compensating the Faculties of Medicine 353
Conference of Mental Health Representatives 242
Creative Protein 348
Deductible Medical Expenses, New Ruling Tells What Are and What Are Not 198
Doctor-Hospital Relationships 354
Do You Plan to Build—Remodel—or Rent? 294
Drugs in Epilepsy 241
Education Versus Service 16
Governor Vetoes Proposed Revision (Senate Bill 247) of the Coroners Act of 1874 351
Graff, M.D. Received Citizens Award, Richard J. .354
Gynecology, A Century of 241
History of Medical Practice in Illinois, The 199
History, Interest in Medical 242
Hospitals to the Nation, Importance of Small 196
Indigent Care Plans, Booklet on 299
Interstate Postgraduate Medical Association 241
Pathologic Diagnostic Service 349
Physician Population, The Nations 197
Pictorial Report on the 1955 Annual Meeting 123
Poliomyelitis Vaccine, The Illinois Plan for the Distribution of 295
Polio Lesson, The 121
Postage Stamps, Medicine on 354
Postgraduate Conferences in Illinois 297
Public Relations in Illinois, Early Medical 299
Report on Your 1955 Annual Meeting 18
Rheumatic Fever, Prevention of 294
Section Officers for 1956 Annual Meeting 122
Statutes of Public Health Significance Enacted by 69th General Assembly 243
Telford "G.P." of Year, Dr. 293
Telford, New Honors for Dr. 350
Thyroid Cancer in Childhood 196
Traffic Safety 21
Urogenital Cancer in Children 293
"Volume 11" 20
Washington, The Month in 34a
Woman's Auxiliary, The 298
Wonder Drugs, The 121
Your President-Elect 18

House of Delegates

First Session 28
Second Session 141
Third Session 150

Medical Economics

Insurance for Freedom in Education, (Wolf) 246
Public Relations, (Portes) 301
Purposeful Living, (Hirsch) 128
Some Economic Aspects of Health Resorts, (Jung) 355

News of the State

Coming Meetings, Personals .....
..... 23, 137, 208, 252, 308, 363

Original Articles

Abortions, Missed, (Smith) 273
Abortion, The Treatment of Threatened, (Paddock) 167
Acute Intestinal Obstruction, (Rudman) 175
Accident Prevention in Childhood, (Gillespie) 327
Alcohol Inhalation in the Treatment of Acute Pulmonary Edema in the Immediate Postoperative Period, (Weyl) 265
Allergy, The Otolaryngologist Looks at, (Derlacki) 1
Allergy, Gastro-Intestinal, (Seagle) 231
Allergy, Useful Drugs in the Treatment of, (Feinberg & Feinberg) 3
Aneurysm of the Splenic Artery, (Colangelo) 223
Cardiac Arrhythmias, Their Prognostic Significance in Recent Myocardial Infarction, (Binder & Sbertoli) 321
Cat Scratch Disease, (Case Report), (Rudman & Cummings) 120
Chronic Gastro-Intestinal Hemorrhage, Diagnostic Enigma, (Case Report), (Pfister & Tatarowicz) .283
Collateral Cardiac Circulation, (Bledsoe) 220
Dermatoses, Oral and Injectible Chlorprophenpyridiamine, Maleate (Chlor-Trimeton Maleate) in the Treatment of Pruritic, (Lackenbacher) 14
Gastro-Intestinal Tract, (Seminar), Newer Concepts of Diseases of the, (Necheles) 275
Guthrie, Samuel, (1782-1848) Physician, Inventor, Chemist, Farmer, (Frederick Stenn) 113
Guthrie Stone, The, (Stenn) 112
Herpes Zoster, Uncommon Sites of, (Norbury) ..226
Keratinization Process, (Seminar) Physiology and Biochemistry of the, (Rotherman) 10
Massive Inversion of the T Wave (Cook County Hospital Case Records), (Goldberg, Shifter & Feldman) 341
Medicine and Citizenship, (Irons) 107
Organized Public Health with Particular Emphasis on Relationships, The Approach of, (Thompson) 330
New Members to Work, Putting, (Roth) 261
Panel on School Health and the Family Physician .325
Pericardial Tamponade Due to Tuberculous Pericarditis, (Cook County Case Record), (Kulis & Saphir) 280
Poliomyelitis, The Practicing Physicians Role in the Control of, (Schulman) 218
Power Lawn Mower Decortication of Scalp and Skull, (Case Report) (Kurth, Drever & Baran) .117
Pulmonary Tuberculosis, Modern Management of, (Lichtenstein) 101
Pyodermas, Management of the, (Shair) 228
Retrolental Fibroplasia Problem, The Extent and Depth of the, (Krause) 337
Role of the Physician in the Parmaceutical Industry, (Seminar), The, (Winter) 334
Health of School Children, (Drennan) 325
Sigmoid-Volvulus, An Unusual Complication of, (Samuels) 236
Situs Inversus Viscerum (Case Report), (Wright) .286
Thermonuclear Fall-Out Problem in the State of Illinois, (Maxwell) 269
Toxemia of Pregnancy, Veratrum Derivatives in the Treatment of, (Raber) 171
Transfusion Therapy-Progress and Problems, 1. Clinical Aspects, (Stern) 315
Trichomonas Vaginitis, Diagnosis and Treatment with Milibis, (Reich, Nechtow, Rubenstein & Doswell) 278
Venous Thrombosis, (Ochsner) 213
Virus Problems in Medicine, (Francis) 257
X-Ray Diagnosis in Pediatrics, (Silverman) 95

Pathology Conferences

Embolic Infarcts of the Brain and Other Viscera with Chronic Rheumatic Endocarditis, and
Acute Thrombo-Ulcerative Endocarditis of the Mitral Valve, (Hirsch) 287
Congenital Stenosis of the Neck of the Urinary Bladder, (Baker & Hirsch) 238
Friedrich's Ataxia Complicated by Chronic Fibroplastic Myocarditis, and
Peptic Ulcer of the Stomach and Sudden, Perforation of a, (Hirsch) 345
Thrombosis of the Basilar Artery, and
Aneurysmal Hemangiectasis (Hemangioma) of The Cerebrum, (Hirsch) 192

The P.R. Page

Sept. 206
Oct. 248
Nov. 303
Dec. 358

Table of Contents

July, 1955
Vol. 108, No. 1

Editor
Harold M. Camp
Monmouth, Illinois

Associate Editor
Theodore Van Dellen
Chicago, Illinois

Business Manager and Managing Editor
Mr. L. E. Malley
185 N. Wabash Avenue
Chicago 1, Illinois

Business Office
185 N. Wabash Avenue
Chicago 1, Illinois

Editorial Office
Medical Arts Building
Monmouth, Illinois

Send original articles and membership correspondence to Harold M. Camp, Monmouth, Ill.

Send changes in the mailing list to Managing Editor, 185 N. Wabash Ave., Chicago 1, Ill.

Subscription price of this JOURNAL to persons not members of the Illinois State Medical Society is $4.00 per year, in advance, postage prepaid, for the United States, Cuba, Puerto Rico, Philippine Islands, Hawaiian Islands and Mexico. $5.00 per year for all foreign countries included in the postal union. Canada, $4.50. Single current copies 50 cents. By mail, 60 cents.

HOUSE OF DELEGATES

First Session 28

ORIGINAL ARTICLES

The Otolaryngologist Looks at Allergy. Eugene L. Derlacki, M.D., Chicago 1

Useful Drugs in the Treatment of Allergy. Samuel M. Feinberg, M.D. and Alan R. Feinberg, M.D., Chicago 5

Physiology and Biochemistry of the Keratinization Process. (Seminar) Stephen Rothman, M.D., Chicago 10

Oral and Injectible Chlorprophenpyridiamine Maleate (Chlor-Trimeton® Maleate) in the Treatment of Pruritic Dermatoses. Rudolph S. Lackenbacher, M.D., Chicago 14

EDITORIALS

Education versus service 16

Report on your 1955 Annual Meeting 18

Your President-Elect 18

The A.M.A. Annual Meeting 19

"Volume II" 20

Traffic Safety 21

Book Reviews 52A

CORRESPONDENCE

Clinics for crippled children listed for August 22

Illinois Association of Medical Health Officers 22

NEWS OF THE STATE 23

Entered as Second-Class Matter November 12, 1952 at the Post Office, Mendota, Illinois, under the Act of March 8, 1879. Acceptance for mailing at special rate postage provided for in section 1102, Act of October 8, 1917, authorized July 15, 1918. Printed monthly by The Wayside Press, Mendota, Illinois. Office of Publication, 1501 W. Washington Road, Mendota, Illinois. POSTMASTER — Return undeliverable copies under form 3579 to 1501 W. Washington Road, Mendota, Illinois.

Today's foremost antibiotic!

ACHROMY

—true broad-spectrum activity

—rapid diffusion and penetration

—prompt control of infection

—negligible side effects

—effective against Gram-positive and Gram-negative bacteria, rickettsia, spirochetes, certain viruses and protozoa

—produced under rigid quality control in Lederle's *own* laboratories

A surgical coronary

A case of successful ligation of the anterior descending branch of the left coronary artery in a 29 year old male is presented. After pericardiocentesis, the patient was taken to the operating room where a 1 cm. would of the right ventricle just below the conus arteriosus and immediately adjacent to the anterior descending branch of the coronary artery was found. The coronary artery and vein were ligated in continuity and the ventricular wound closed. The patient made a complete clinical recovery and has returned to heavy physical labor. Serial electrocardiographs showed a typical anterior myocardial infarction with return to normal in 8 months. *W. Albert Brewer, M.D. and Fred W. Holmes, M.D. Successful Ligation of the Anterior Descending Branch of the Left Coronary Artery. Henry Ford Hosp. Med. Bull. March* 1955.

‹ ›

Teaching in the home

A recent homemaker survey of two urban areas demonstrated the large educational role physicians play in the dissemination of nutritional information. Thirty-eight per cent of the housewives said the doctor was the major source of their information. Interestingly enough, the survey revealed that radio was of the same order and importance in this regard as physicians. Only newspapers, magazines, and television came ahead of the physician and radio as sources of nutritional facts for homemakers. *Editorial. New York J. Med. March* 1, 1955.

‹ ›

Thousands of people are abroad in the country with tuberculosis which is arrested or inactive following treatment. Antibiotics have played a large part; and we hope these people will remain well for many years, but how many will relapse we do not know. How many may at some time produce tubercle bacilli, which may be a danger to the community, we do not know. Will the antibiotics lose their effectiveness as the number of resistant cases increases in the community? Again, we do not know. It is such uncertainties that lead the pessimists to say that tuberculosis, like the poor, will be always with us. Geo. J. Wherrett, M.D., Nat Tuberc. A. Tr., 1954.

METICORTEN

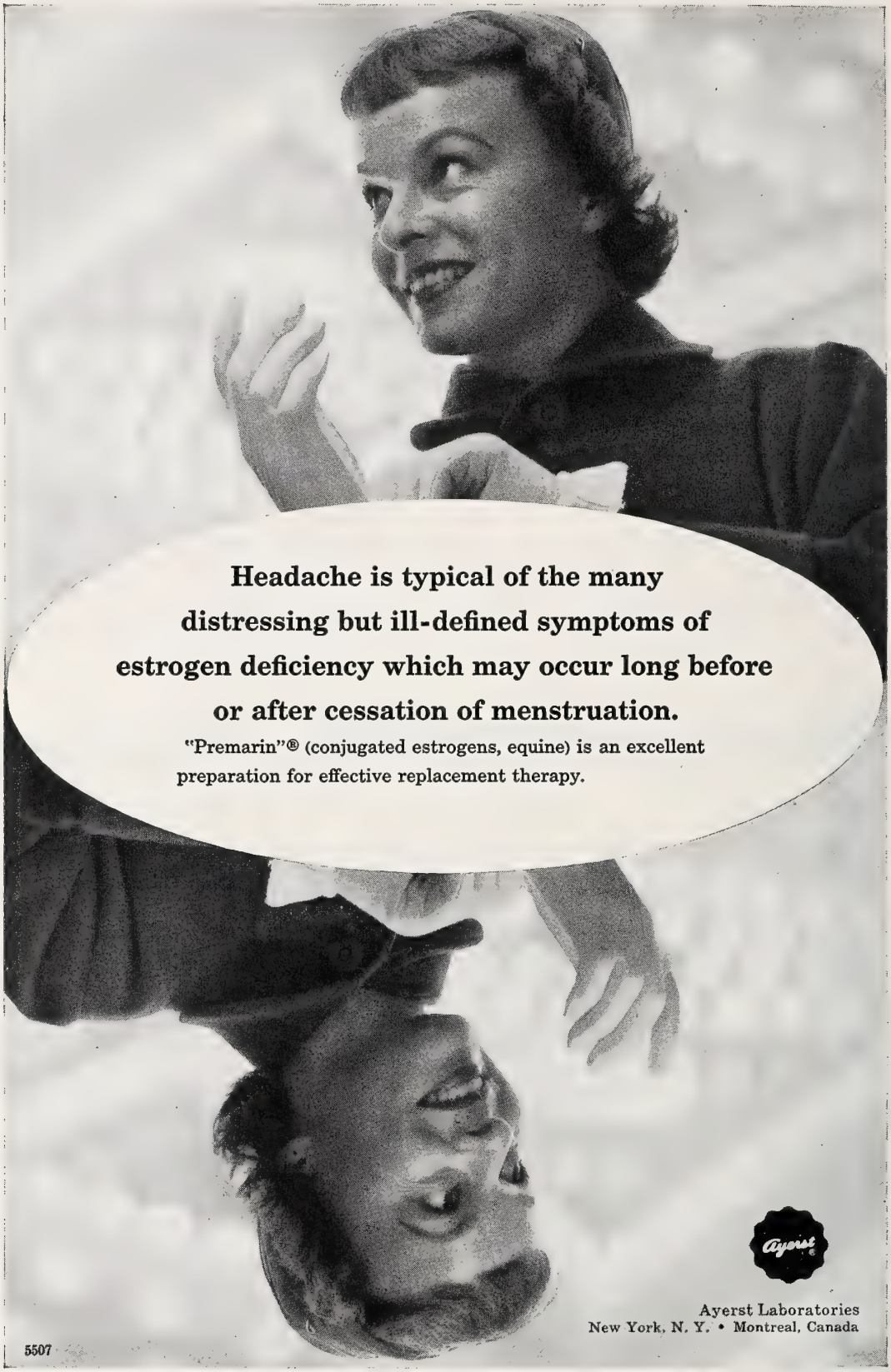
PREDNISONE (metacortandracin)

Schering

more potent than cortisone
or hydrocortisone · devoid of
major undesirable side effects

*T.M.

METICORTEN,* brand of prednisone.


Headache is typical of the many distressing but ill-defined symptoms of estrogen deficiency which may occur long before or after cessation of menstruation.
"Premarin"® (conjugated estrogens, equine) is an excellent preparation for effective replacement therapy.
Ayerst
Ayerst Laboratories
New York, N. Y. • Montreal, Canada
5507

The
ILLINOIS
Medical Journal

Official Journal of The Illinois State Medical Society

JULY 1955
VOL. 108 NO. 1

The Otolaryngologist Looks at ALLERGY

Eugene L. Derlacki, M.D., Chicago

IN 1950 a historical review of allergy in otolaryngology was presented by Hansel[1] who pointed out that, although the allergic nature of vasomotor rhinitis was first suggested about 1906, nasal allergy as a definite clinical entity was not established until about 15 years later. Within the next five years allergy as the cause of chronic paranasal sinus disease began to gain recognition. However, the management of chronic nasal and sinus disease was dominated by surgical thinking at the time, and there was neither the feeling nor the inclination in otolaryngology to become oriented in antigen-antibody reactions. This indifference to allergy in a specialty preoccupied with the problem of infections lasted in spite of the pioneering efforts of Hansel until about 15 years ago.

The advent of the sulfonamides and, more recently, the antibiotics has produced a much discussed change in the field of otolaryngology, part of which has been an increasing awareness of the role of allergy in the specialty. The use of chemotherapy and antibiotics has greatly reduced the time and energy devoted to the management of infection, and at the same time, has shown that certain acute and chronic conditions in the ear, nose and throat previously always considered to be primarily infections did not respond to these drugs which ordinarily control and cure infection. Thus, another etiology has had to be sought for many of these conditions, and allergic investigation and management has provided the answer in many instances. Peshkin[2], an outstanding pediatric allergist, in discussing the future of allergy in otolaryngology stated "In view of . . . . . the foregoing considerations, the otolaryngologist has to broaden his knowledge of medicine if he is to survive in his specialty . . . . . Each specialist must consider and treat the allergic conditions found in his specialty as local manifestations of a systemic disturbance."

What are the diseases of the ear, nose and throat due to the autonomic dysfunction initiated by antigen-antibody reaction which is termed specific allergy? To try to answer this question in detail is impossible in a twenty minute presentation, but I hope the following remarks will be a start in this direction.

Nasal allergy is responsible for most of the complaints in the practice of rhinology. Allergic rhinitis includes not only the typical seasonal hay fever, but also the conditions known as vasomotor rhinitis, hyperaesthetic rhinitis, intumescent rhinitis, catarrhal rhinitis and hypertrophic rhinitis. All of these conditions are

merely varying degrees of perennial nasal allergy, often with superimposed secondary infection. Certainly, some cases of atrophic rhinitis, too, are the end result of perennial allergic rhinitis of many years duration.

The symptoms of chronic allergic rhinitis are variable depending upon the duration, the amount of secondary infection and, to some extent, upon the allergen; inhalants tending to produce paroxysmal sneezing and watery discharge, and foods tending to produce a more continuous obstruction. All varieties and gradation of symptoms are found from the typical bouts of sneezing, watery discharge, lacrimation and nasal blocking in seasonal hay fever, to the less dramatic but more frequently encountered complaints of increased post-nasal discharge or nasal stuffiness.

The pathology of allergic rhinitis may be termed allergic inflammation with characteristic findings in contrast to inflammation due to acute or chronic infection. The allergic reaction in respiratory mucosa consists first of edema of the sub-epithelial connective tissue. Where this tissue is quite loose, as in the mucosa lining the sinuses, marked watery bag-like edema occurs, eventuating in polyp formation. Secondly, the allergic reaction causes a tremendous stimulation of the mucous glands in the sub-epithelial connective tissue, and in the epithelium itself where the goblet cells multiply and replace many or even all of the ciliated cells, with failure of cilia activity as has been demonstrated in fatal cases of bronchial asthma. Thirdly, the allergic reaction is accompanied by the local accumulation of eosinophils in the tissue. Since the respiratory mucosa is semipermeable both to edema fluid and to eosinophils, a watery discharge containing mucous and eosinophils accompanies the allergic reaction. Of fundamental importance is the fact that an allergic reaction of the respiratory mucosa tends to involve all of the mucosa simultaneously, though not to an equal degree.

The diagnosis of chronic nasal allergy is made from the symptoms, the appearance of the nasal mucosa, cytologic examination of the nasal smear and the response to the therapeutic test. As stated above, the symptoms are variable and tend to be persistent for weeks and months; nasal blocking, sneezing and discharge being particularly characteristic of the allergic reaction. The nasal mucosa is typically pale, edematous, boggy, with increased clear or thick tenacious mucous, but in some cases the nasal mucosa may be red, or blue (cyanotic). Nodular hypertrophies may be found particularly on the posterior end of the inferior turbinate, where the bluish-red nodular enlargement resembles a mulberry. The chronic edema of the nasal mucosa in allergic rhinitis frequently results in the formation of polyps, especially on the middle turbinate, and projecting from the ethmoid cells. These polyps, resembling small oysters, may competely fill the nasal passages, and may even protrude into the nasopharynx.

Cytologic study of the stained nasal smear in allergic rhinitis will show the presence of eosinophils in varying amounts depending on such factors as the concentration of the nasal secretion and the degree of superimposed secondary infection.

In the last analysis the proof of an allergy depends upon the therapeutic test: if removal of a specific substance or treatment with an extract of this substance relieves the symptoms, and if the symptoms recur on re-exposure, or after the treatment has been discontinued, we may assume that the particular substance is responsible for the symptoms.

The treatment of chronic allergic rhinitis is to find and to eliminate the specific sensitivity. Symptomatic treatment includes vasoconstricting nose drops, the surgical removal of polyps and hypertrophies, applications of various cauterizing agents to the mucosa to produce fibrosis and in recent years the various antihistaminics. Temporary improvement in the symptoms may be obtained by these means, but unless the underlying allergic factor is discovered and appropriately treated, the relief will be only partial and temporary. It must be remembered that allergic disease may be controlled with more or less freedom from symptoms, but the allergic patient will always have the tendency to develop clinical allergies.

One of the most abused diagnoses in medicine is that of sinusitis. Actually, clinical sinusitis is an inflammation, allergic or otherwise, of the mucosal lining of a sinus with retained secretion. The sinuses are diverticula of the nasal cavity lined by an extension of the respiratory mucous membrane. Thus, every case of chronic rhinitis is reflected by similar changes in the sinuses.

The edema and other mucosal changes in the sinus are part of the nasal mucosal reaction as described previously, and produce no special symptoms while the sinus ostium remains unobstructed. However, occlusion of the ostium by edema results in retained secretions, and the symptoms of a clinical sinusitis arise.

Cases of chronic sinusitis can be differentiated into two etiologic groups. The relatively infrequent chronic anaerobic infection, usually of an antrum, predominantly due to extension from an abscessed upper molar tooth or occasionally following a virulent acute upper respiratory infection responds extremely well to penicillin irrigation of the sinus. In our experience, over 90% of chronic sinusitis is the chronic allergic type based upon an allergic rhinitis with obstructing edema of the sinus ostia. Stasis predisposes to infection, and infection superimposed upon a chronic allergic state tends in turn to become chronic.

The symptoms of chronic allergic sinusitis are pronounced and frequently out of proportion to the actual infection. They are principally the symptoms of chronic allergic rhinitis with more profuse muco-purulent nasal discharge. Transillumination or x-ray of the sinuses, and the observation of muco-pus in the middle or superior meatus can give evidence of retained sinus secretions, but irrigation of the sinuses is the most reliable proof of retained secretions. Cytologic study of the sinus washing will reveal cosinophils. While secretion may be present in only one sinus, all the sinuses will show some edema of the mucosa by x-ray, but this edema can fluctuate considerably from day to day.

The successful treatment of chronic allergic sinusitis depends primarily upon specific allergic management, and the secondary infection may or may not require irrigation or, rarely, sinus surgery for complete relief.

Other portions of the upper respiratory tract, such as the naso- and oro-pharynx as well as the gateway to the lower respiratory tree, the larynx, can all participate in the allergic reaction. The vocal cords are prone to vasomotor involvement with eventual hyperplastic or polypoid change. Frequent recurrence of hoarseness, or hoarseness of widely fluctuating degree, is very characteristic of allergic laryngitis. The recurrent or persistent sore throat, usually afebrile but sometimes even with low-grade fever, will often be an allergic naso-pharyngitis and/or pharyngitis with mucosal edema, or a pharyngeal myalgia with ischemic spasm in localized areas of the constrictor muscles. The pronounced nasopharyngeal and lymphoid hyperplasia in the child or even the adult — the hypertrophied adenoid remnant, the prominent lateral bands or the so-called granular pharyngitis — is in my experience most often an expression of respiratory allergy.

General acceptance and recognition of allergic nasal and sinus disease antedates considerably the growing awareness of allergic disease involving the ear. In the past 5 to 7 years an increasing number of reports in the literature are adding to our knowledge of allergic ear disorders. In a previous article, this writer[3] reported that in a review of 993 new otologic cases seen in our practice in one year from May 1951 to May 1952, 115 cases (11.6 per cent) were considered to be allergic in origin.

Allergic involvement of the skin of the auricle and of the external auditory canal can vary from an itching, dry, scaly skin to the weepy eczematoid lesion often seen elsewhere on the body. The latter often becomes secondairly infected by such organisms as B. Pyocyaneus, staphylococcus or streptococcus producing a painful, diffuse external otitis with marked stenosis of the ear canal and purulent secretion. Such variable allergens have been found to be responsible as foods, inhalants, cosmetic contacts and drugs. This same type of reaction can occur in the skin lining a previously dry and healed fenestration or mastoid cavity.

Allergy of the middle ear is encountered more frequently than allergy of the outer or inner ears. The persistent, therapy-resistant, mucoid draining middle ears with central perforations of the eardrum are much less influenced by the infecting organism than by the underlying allergic tissue response. Eosinophils may be demonstrated is such ear secretions. These cases resist therapy as a rule until the allergic factor is controlled. A recent study of a technic for closure of long-standing central perforations of the tympanic membrane showed us that of 129 of these cases with chronic suppurative otitis media 46 were allergic.

Allergic involvement of the mucosa of the

eustachian tube and of the middle ear can also produce repeated attacks of acute otitis media or of chronic secretory otitis media. An underlying allergy may be responsible for any case of chronic secretory otitis media not due to an obvious obstruction of the eustachian tube by tumor or adenoid. The coincidental finding of a chronic nasal allergy enhances the likelihood of establishing an allergic factor as being responsible for middle ear allergy. Successful allergic management of chronic secretory otitis in children along with thorough adenoidectomy is the best means of preventing the cases of irreversible conductive hearing lesions due to chronic adhesive otitis and acquired cholesteatoma which are the all too frequent sequelae of long-standing chronic secretory otitis media. Too often we see these cases treated with repeated courses of antibiotics and roentgen or radium irradiation of the nasopharynx to no avail.

Less frequently we have been able to demonstrate allergy of the inner ear. Anywhere from 5 to 13 per cent of our cases of labyrinthine hydrops (Meniere's disease) have been primarily due to a specific allergy. The clinical picture of hydrops of the labyrinth is characterized by a low-tone nerve deafness which usually fluctuates widely, at least in the early stages, by a sense of fullness or pressure in the ear, a roaring type of tinnitus and paroxysmal attacks of vertigo. Since, in our experience, the specific allergic cases of Meniere's disease have resulted in the best possible therapeutic results, an allergic etiology should never be overlooked in this condition.

I must also mention without elaboration on the subject that a knowledge of allergy or autonomic dysfunction certainly enhances the understanding of such related vascular head pains as migraine, tension headaches, histaminic cephalgia, allergic headache and many so-called cranial neuralgias.

Finally, one must not forget that our greatly expanding armamentarium of drugs, including sulfonamides and antibiotics, may produce various allergic lesions, urticarial, angioneurotic edematous, and others, in the field of otolaryngology for which one must always be on the alert.

In conclusion, I hope that this superficial review of the subject gives some indication of what an important factor allergy has become in the modern practice of otolaryngology.

REFERENCES

1. Hansel, F. K.: Allergy in Otolaryngology: Historical Review, Supp. to Tr. Amer. Acad. Ophth., pp. 3-8 (Feb.) 1951.
2. Peshkin, M. M.: The Future of Allergy in Ophthalmology and Otolaryngology, Supp. to Tr. Amer. Acad. Ophth., pp. 9-12 (Feb.) 1951.
3. Derlacki, E. L., and Shambaugh, G. E., Jr.: Allergic Management of Some Common Ear Conditions, Tr. Amer. Acad. Ophth., Vol. 57, No. 3: 304-311 (May-June) 1953.

« « « » » »

Coronary thrombosis prevention

From all present indications, the problem of coronary heart disease lies primarily in the realm of preventive medicine. The means are already at our disposal, via lipoprotein analysis, for identifying at any early period of life those individuals characterized by an excessive risk of premature coronary heart disease. Further, that risk can be described in quantitative terms. Some methods, by no means perfect or universal, are available to reduce lipoprotein levels in those persons characterized by extremely high risks of development of coronary heart disease. The early identification of persons with high coronary disease risk via lipoprotein measurement plus efforts to alter their outlook by measures directed toward lowering of lipoproteins appears to provide highly hopeful avenues of approach to the reduction of coronary disease mortality. *John W. Gofman, M.D. Some Concepts of the Problem of Coronary Heart Disease in Industry. Indust. Med. April* 1955.

Useful Drugs in the Treatment of Allergy

SAMUEL M. FEINBERG, M.D. and ALAN R. FEINBERG, M.D., CHICAGO

IT is not our purpose to present new or experimental drugs which may still be unavailable to the general medical profession or be insufficiently tried. The drugs discussed here are those which all of you know well. The purpose of this presentation will be rather to give you our experience as to when to use them, how to use them and when not to use them.

SYMPATHORIMETIC DRUGS

This constitutes the large class of drugs which owe part of their action to vasoconstriction, although some of them possess other important physiological activities.

Epinephrine is commonly used in asthma and in other acute allergic reactions. The usual form is a 1:1,000 aqueous solution of the hydrochloride and the average dose for asthma should be .30 to .35 cc. Administering 1 cc of this solution or the entire contents of an ampoule frequently results in severe reactions, such as marked tachycardia, hypertension, severe headache, chills and nervousness. If asthma responds little to epinephrine, then the use of excessive amounts, such as an injection every hour, can be harmful because other undesirable effects of this drug can still be present. Many physicians fear to use epinephrine in the presence of hypertension or cardiac disease. The fact is that in moderate hypertension this drug is not contraindicated, since its use may actually result in a lowering of the pressure secondary to the diminished heart work from the relief of the asthma. Since epinephrine dilates the coronaries it is not contraindicated in coronary disease other than in the presence of a recent infarct. In general, it may be said that this drug is seldom contraindicated in cardiovascular disease.

Epinephrine base in oil for slow absorption cannot be recommended in most instances. It has been shown both in experiments on dogs and in observations on man that such preparations are unpredictable in their absorption. Sometimes they will absorb so slowly as to be insufficiently effective. At other times the entire dose of the drug may be absorbed at once, producing some of the most alarming symptoms of epinephrine intoxication. The only manner in which we favor the use of epinephrine in oil is its administration in an amount about .2 or .3 cc several minutes after the effect from an aqueous solution has been obtained. Epinephrine solution 1:100 nebulized as an aerosol is an effective home remedy for relief of asthma. Patented preparations of solutions for nebulization have no advantage. It should be remembered that excessive use of such epinephrine therapy may also result in cardiac stimulation, hypertension, nervousness, insomnia and other symptoms of toxicity. Local damage in the pharynx, larynx, bronchial tree and nose may also follow.

Ephedrine is the most active of the sympathicomimetic drugs used orally. It is most useful in asthma and less effective in vasomotor rhinitis and urticaria. Because of its stimulating effect it is commonly combined with a small dose of a barbiturate. Ephedrine may produce over-stimulation of the central nervous system, tachycardia and difficulties in urination, particularly in men past middle age. *Racephedrine* may be tolerated when ephedrine is not. If the patient cannot take racephedrine, *propadrine* is worth trying. This should be administered in about twice the dosage (¾ gr.) of that of ephedrine. *Clopane* is a sympathomimetic drug which has found some use particularly in nasal conditions. It is usually combined with an antihistamine, in such preparations as Histaclopane or Co-Pyronil.

Presented at the Section on Allergy. One Hundred Fourteenth Annual Meeting of the Illinois State Medical Society, Chicago, May 20, 1954.

Vasoconstricting local medications for the nose are numerous. Among the most common, in approximate order of intensity of action, are solutions of privine, neosynephrine, ephedrine and propadrine, and Benzedrex inhaler. It has been adequately established that sprays or drops of a vasoconstrictor are harmful to the persistent nasal allergy. After the effect of the vasoconstrictor wears off there occurs compensatory vasodilatation with increased swelling of the tissue and increased demand for the medication. This results in a vicious cycle which may eventuate in a frequent use of the drops and an augmented nasal congestion. For occasional use in a badly stuffed nose, or in the case of an acute nasal infection where drainage is desired, such medication is helpful.

BRONCHODILATORS

Aminophylline is a useful drug in asthma. It may also be a valuable supplement to the use of epinephrine in a constitutional allergic or anaphylactic reaction involving the bronchi. The usefulness of aminophylline or other bronchodilators in asthma is dependent on the relative importance of bronchospasm as a main feature of the attack. This can be only ascertained by therapeutic trial. Intravenous administration is most effective, the usual dose being 250 mg (3 ¾ gr). It should be injected slowly, in order to prevent undue cardiac or nervous stimulation. In the form of a suppository or rectal installation this drug, in doses one to two times the intravenous, may constitute a good home remedy for asthma. Many patients object to the rectal irritation produced by such therapy. Orally aminophylline has the least effect and is a gastric irritant. If used in large doses it should be given in enteric coated tablets. Combination with aluminum hydroxide (Cardalin) also minimizes the gastric irritation. Small doses of aminophylline are commonly combined with ephedrine as anti-asthma remedies. When large or frequent doses of the drug are used it is wise to add sedative medication.

Isopropyl epinephrine (*Isuprel, Norisodrine*) is a bronchodilator of about the same order of potency as epinephrine when used as an aerosol. It has the cardiac and nervous system stimulating effect of epinephrine but lacks the pressor activity of the latter. In a solution 1:200 or 1:100 nebulized as an aerosol we have used it in the last few years, virtually replacing ephinephrine aerosols. It is also available in the form of a diluted powder to be inhaled through a special inhaler. At times such powders are more helpful than the aerosols. Sublingual tablets (usually 10 to 15 mg) may also relieve asthma, but are more frequently accompanied by systemic symptoms such as tachycardia and nervousness. It is important to keep in mind that this drug cannot replace epinephrine in those allergic conditions requiring vasoconstriction (edema, allergic constitutional reaction) nor in the treatment of shock.

Other bronchodilators may be helpful at times. Among these may be included caffeine sodium benzoate, coffee, and alcoholic liquors. Inhalation of smoke of the burning powder or cigarettes containing stramonium and potassium nitrate also acts as a bronchodilator. This form of treatment cannot be particularly recommended since other elements in such smoke may perpetuate and enhance the bronchial irritation. The oral or hypodermic use of Khellin preparations as a bronchodilator has been found disappointing.

ANTIHISTAMINES

The antihistaminic drugs are helpful in mild cases of nasal allergy, particularly where sneezing is the major symptom, in some instances of allergic cough, in many patients with moderate urticaria, and in many other conditions where the relief of itching is desirable. In asthma these drugs are seldom useful, except as supplements to other more effective drugs, or in asthma in young children. In the obstructive stage of seasonal hay fever or perennial vasomotor rhinitis they usually produce little benefit. In severe cases of urticaria, angioneurotic edema or "serum-sickness" type of reaction from serum or penicillin they may be ineffective, particularly if employed in the usually accepted average dosage. No reliance should be placed on the antihistamines in the treatment of an anaphylactic shock or a severe acute allergic reaction, where epinephrine should be the drug of choice. In such instances the antihistamine may be given hypodermically or intravenously, only as a supplement to epinephrine. Topically, antihistamine nasal sprays may be useful in nasal allergy; antihistamine aerosols may be effective in some instances of

allergic cough or asthma; as eyedrops they may be beneficial in cases of allergic conjunctivitis; and as creams or ointments they may relieve the itching in dermatoses and that resulting from insect bites.

Since there are now several dozen varieties of antihistaminic drugs and since individual manufacturers frequently attribute superior virtues to their particular products it has become an extremely confusing problem for the average practitioner to make a choice. Thus it is frequently true that the antihistamine which is a favorite with a particular physician owes its favor not to any special virtues but to the forcefulness of the advertising campaign of its manufacturer or the persuasiveness of the detail man. It is impossible or unnecessary for anyone to use all the antihistaminic drugs. We can divide the antihistamines into three groups. Group 1 would include the highly sedative, therapeutically potent drugs. This includes primarily Benadryl, Decapryn and Phenergan. Group 2 comprises the mildly sedative antihistamines. These include chiefly Antistine, Neohetramine and Thephorin. The first two are also less potent than the average. Group 3 comprises the majority of drugs, which are moderately sedative and most of which are also highly effective. Among these are Clistine, Chlortrimeton, Diatrin, Di-Paralene or Perazil, Histadyl or Thenylene, Neoantergan, Pyribenzamine, Pyrrolazote, Tagathen and Trimeton. We advise the physician to become familiar with one member from each group, (such as, for example, Pyribenzamine, Benadryl and Thephorin; or Thenylene, Phenergan and Antistine; or Pyrrolazote, Decapryn and Chlortrimeton). Most patients who respond to antihistamines will obtain an effect from one or the other of such a trio. If the patient is easily sedated a mild drug should be tried. If sedation is an advantage a member of Group 1 should be chosen. The duration of effect of most antihistamines is about 4 hours. Phenergan and Di-Paralene (Perazil) have a more lasting effect. Occasionally one has to resort to trial with a number of additional antihistamines. If the particular antihistamine is effective yet too sedative it is possible to neutralize the sedative action by the addition of 2.5 to 5.0 mg. of dextro-amphetamine or by ephedrine.

EXPECTORANTS

Iodides produce a serous bronchial secretion which contributes to the relief of the asthma by making terminal bronchial plugging less likely. There is no virtue in giving the iodides intravenously since absorption is rapid when given orally. Potassium iodide, about 10 grains three to four times daily, and well diluted, constitutes the usual dose. This drug is also available in enteric coated tablets. It should be remembered, however, that gastric symptoms from iodides are not due entirely to the direct contact of the swallowed dose. It is due in large part to the excretion of the iodide by the gastric and salivary glands. In addition to the gastrointestinal side effects which may include nausea, gastric discomfort and diarrhea, other untoward results may be produced by iodides. One of the most common is an acneiform eruption, which is more prone to occur in those who have had a prior tendency to acne. Much less often but more disturbing is the swelling of the salivary glands. Some patients respond by increased rhinorrhea and an irritative cough. In such individuals the respiratory complaints may be actually aggravated. Iodides find their greatest usefulness in prolonged or persistent asthma, where cough persists and where distress occurs from efforts to raise sputum. In many instances we believe it is advantageous to add apomorphine hydrochloride 1/16 gr. (4 mg.) to each dose of the iodide.

When iodides are not tolerated other expectorants may be tried. Ammonium chloride may be helpful. Ipecac may be effective as an expectorant, although an emetic dose may be more quickly beneficial. Inhalations of carbon dioxide may also have an expectorant effect.

SEDATIVES

Sedatives are employed in allergic manifestations for the purpose of allaying apprehension due to the disease, for promoting sleep and for counteracting the effects of stimulating medication. Barbiturates are usually adequate for the relief of overstimulation from medication. In some instances barbiturates may cause sensitization. Chloral hydrate is the preferred drug in asthma. Opium derivatives are contraindicated in asthma because of their tendency to depress respiration, suppress the cough reflex and augment bronchospasm. While not as ob-

jectionable as morphine, demerol still carries a good deal of hazard.

MISCELLANEOUS DRUGS

Numerous miscellaneous drugs have been used in allergic disease, of which three or four are worthy of mention here. Not infrequently the patient with asthma or vasomotor rhinitis feels that he is benefited by *aspirin*. In the majority of cases not only will aspirin fail to give relief but there may be violent allergic symptoms from it in some. Aspirin is noted for its tendency to produce severe urticaria and angioneurotic edema and the most severe type of acute asthma. Individuals allergic to aspirin are frequently allergic to other analgesics such as acetaphenetidine, acetanilid and aminopyrine. We have found that a relatively new analgesic, N-acetyl-p-aminophenol (Apamide, Ames) has been tolerated well by these patients; the dose is about the same as that of aspirin.

Antibiotics may be highly effective in acute infections of the respiratory tract responsible for asthma; they are of little value in chronic asthma associated with bronchial infections. It is important that the asthmatic or allergic patient not be subjected to unnecessary treatment with antibiotics, since it is particularly this group of individuals which is prone to become sensitized to these drugs, especially penicillin. A large percentage of the severe immediate, anaphylactic or fatal penicillin reactions has occurred among those who have had previous treatment with this drug. A negative skin test has no bearing on the possibility of the delayed, serum-sickness type of reaction which occurs several days after penicillin administration. A positive test, however, signifies that the patient would very likely experience an immediate and serious reaction from its therapeutic administration.

Ether is one of the most effective remedies in status asthmaticus. It is best administered rectally using about 3 to 4 ounces with an equal amount of warmed vegetable oil. Doses of an ounce or so may be repeated every two or three hours for a period of 24 hours. In the last few years the use of an old remedy, arsenic, has been revived in the treatment of asthma. This is the major ingredient of medication dispensed at the Mecca which has attracted thousands of patients from thousands of miles away. We have used the identical medication and find that its virtues, as the reports of Mark Twain's death, are "highly exaggerated." At any rate, such medication may be obtained at any corner drug store for a few cents on the prescription of one's own family physician.

STEROID THERAPY

Corticotropin (ACTH), cortisone and hydrocortisone are a real addition to the therapeutic armamentarium of allergy. It is the unfortunate experience of any new therapy that there is a period during which the remedy is misused and abused, and these hormones are certainly no exception. In status asthmaticus when the ordinary medication has failed the hormone therapy is usually indicated, with the intent of tiding the patient over a critical period. In some cases of persistent asthma, where allergic factors are unknown or where other approaches have failed, this therapy may be indicated for prolonged use. Occasionally it is desirable in atopic dermatitis, seasonal hay fever, severe perennial rhinitis and the severe urticarial dermatoses. In the serum-sickness type of reactions from penicillin or serum when antihistamines fail ACTH or cortisone should be used.

Cortisone or ACTH cannot work rapidly enough to constitute emergency treatment in acute asthma or in an anaphylactic reaction. These drugs are not indicated as a substitute for simple symptomatic treatment, nor should they take the place of an investigation of the causes and the specific management of the allergic syndrome. They must be used with great caution or not at all in the presence of such conditions as hypertension, cardiac failure, coronary disease, diabetes, peptic ulcer, tuberculosis, neuroses and psychoses. The usual precautions in connection with the administration of these hormones must be observed. These include a restriction of sodium, supplementary potassium, repeated examination, weight gain, blood pressure, and signs of hormone influence and nervous changes. These drugs should only be administered when the patient is under direct observation of his physician so that untoward effects may be prevented or noted and the dose properly regulated.

In most instances both ACTH and cortisone produce similar therapeutic effects and side ef-

fects. Cortisone is usually preferrable because the medication can be administered orally. In an occasional patient ACTH appears to work better, while the reverse situation may also occur. It is our impression that the onset of relief occurs more rapidly with ACTH. But in either case it takes several to 48 hours to obtain satisfactory results. The initial dose of cortisone is 150 to 300 mg daily (usually 200 mg) divided into 4 doses. After two days if partial relief is obtained the daily dose is reduced to 150 mg. If improvement progresses the dose may be reduced to 100 mg. two days later. From that point on reduction of the dose should be more gradual and at longer intervals. The maintenance dose in asthmatic patients is usually from 50 to 100 mg. daily: ACTH is usually administered in the form of ACTHAR Gel, 50 units, intramuscularly twice daily, with comparable reductions in the dose later. The maintenance dose of 20 to 40 units can usually be administered in one daily dose. At times we employ a combined medication beginning with a full dose of ACTH and a moderate dose of cortisone. When improvement begins the ACTH is rapidly reduced while the cortisone dose is kept constant. When therapy with either of these hormones is to be discontinued the dose should be gradually reduced over a period of several days. Failure to do this may result in a severe relapse due to depression of the pituitary-adrenal system.

Hydrocortisone or Compound F is as effective, and perhaps slightly more effective, milligram for milligram, than cortisone. There is no essential difference in side actions nor any increase in the speed of results as compared to cortisone. Topically, hydrocortisone has proved to be one of the greatest advances in dermatologic therapy in recent years. Ointments of this hormone, usually in 1 to 2 ½ per cent, applied two or three times daily will improve many types of localized dermatoses in 48 hours or even less. It has been found useful in atopic dermatitis, contact dermatitis, seborrheic dermatoses, pruritus ani and vulvae, and insect bites. Ophthalmic ointments produce relief in allergic and other types of conjunctivitis. In the form of drops or sprays it may give relief in allergic rhinitis.

SUMMARY

In the symptomatic treatment of allergic manifestations drugs are available which can produce relief by various mechanisms. Such drugs may be listed as sympathomimetics, bronchodilators, expectorants, antihistamines, sedatives, antibiotics and steroid hormones. The proper use of each particular class of drugs, the judicious selection of an individual drug in the group, the knowledge of how to administer the drug and when not to administer it, can contribute materially to the effectiveness and safety of the symptomatic treatment of allergy.

185 North Wabash Avenue

Addendum: Since this paper was presented we have had intensive experience with a new steroid, Meticorten in asthma. This hormone is 5 to 8 times more potent than cortisone and has much less tendency to produce water retention or to deplete potassium. Some patients who have failed to respond adequately to cortisone have responded to Meticorten.

Physiology and Biochemistry of The Keratinization Process

Stephen Rothman, M.D., Section of Dermatology, Department of Medicine, University of Chicago.

THERE are some biochemists who emphatically claim that there is only *one* biochemistry, a biochemistry at the cellular level; that there is little difference in the biochemical behavior of ameba and man, and also that all organs of the differentiated higher forms operate essentially with the same cellular mechanisms. — While it is true that many basic biochemical processes are identical in all living cells and tissues and that fundamental, generally valid discoveries were made by the use of pigeon liver homogeneates alone, still the fact remains that certain organs perform special functions and that the functions require special biochemical reactions. In the case of the skin, the keratinization process, production of sweat and sebum are unique and highly specific functions of this organ. Moreover, according to newer data such general biological processes as the metabolism of pyruvic acid via the citric acid cycle apparently does not operate in the skin but is rather cut short to a rudimentary cycle.

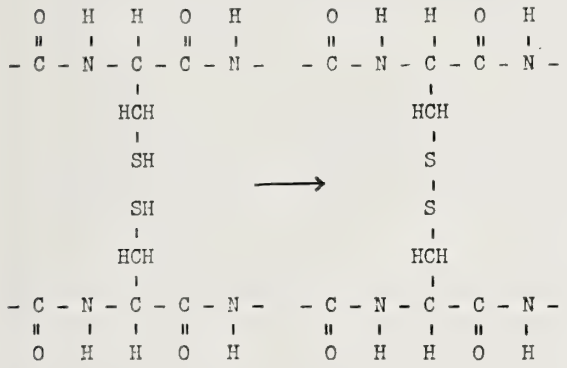
In my presentation today I would like to discuss the biochemistry of the keratinization process as one of the most characteristic and clinically most important functions of the skin.

The germinative cells of the epidermis, hair and nails have an intrinsic life cycle. As they multiply and their daughter cells approach the surface they undergo profound changes until their life terminates with the formation of dead anuclear horny cells. — In these cells most of the native cell proteins have been transformed into keratins. The keratins are proteins with a marked resistance to the action of proteolytic enzymes. X-ray diffraction studies have shown that while in most cellular proteins the polypeptide chains are coiled like a ball of yarn ("globular proteins"), keratins of hair, nail and the horny layer belong to the group of fibrous proteins and consist of more or less straightened polypeptide chains. Hair keratins, for instance, consist of elongated molecules, about 100 times larger in length than in width. In their natural state, the keratin fibres are not maximally stretched. They have so-called alpha folds in regular intervals. Therefore, keratin fibres can be stretched into the so-called beta form, a potentiality which is exploited in the procedures of permanent waving of hair. The alpha folds may play a role also in the physiological resiliency of the horny layer. Because most cellular proteins are tightly coiled while the keratins represent parallel elongated molecules, it would appear that the keratinization process is connected with an unfolding of polypeptide chains. But this is not certain because the living cells of the Malpighian layer do contain fibrous proteins, the tonofibrils, which also have an alpha keratin spectrum. It was thought for some time that keratinization consists of nothing else but disintegration of the nonfibrous parts of the cell; the remaining fibrous parts, the tonofibrils, conglomerate and form the horny fibers. However, this hardly can be true because the final horny fibers in the horny layer are considerably more resistant to peptic and tryptic digestion than are the tonofibrils in the living part of the epidermis.

We know some of the factors which are responsible for the high resistance of keratins

SEMINAR
of the Department of Medicine of the University of Illinois
Edited by:
Max Samter, M.D.
Associate Professor of Medicine
Alexander Remenchik, M.D.
Clinical Instructor in Medicine

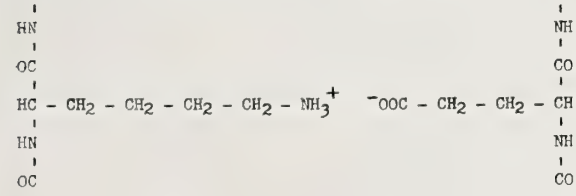
to proteolytic agents. First, there are disulfide bridges connecting neighboring polypeptide chains. During keratinization when folded polypeptide chains unfold it happens that the sulfhydryl (-SH) groups of built-in cysteine radicals on neighboring chains get sufficiently close to each other to react and undergo a so-called "oxidative closure". (Figure 1.) In



Formation of disulfide bond

Figure 1

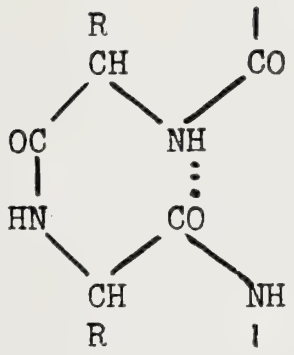
fact, in the zones just below the horny layer ("keratogenous zone") the sulfhydryl concentration is excessively high (due to unfolding?) while in the horny layer itself the color reactions for sulfhydryl are entirely or almost entirely negative. A second type of bonds which contribute to the solidity of keratin molecules are the salt linkages, electrostatic attractions between the free acidic group of a dicarboxylic acid and the free basic group of a diamino acid on neighboring chains (Figure 2). These



Salt linkage

Figure 2

salt bonds are broken by mineral acids or alkalis so that water can enter between the crystallites and the keratin fibers may swell. — A third type of linkage is the hydrogen bonding which is found both within the alpha folds of the long chains (Figure 3) and in between neigh-



Hydrogen bonds within the polypeptide chain

Figure 3

boring chains. — The knowledge that hydrogen bonds contribute to the solidity of keratins has led to a new type of experimental dissolution of keratins. Concentrated lithium bromide solutions break hydrogen bonds and it could be shown in my laboratory that by lithium bromide treatment hair can be made so permeable that ringworm fungi inside the hair can be killed easily after such treatment. We also obtained some encouraging results in treatment of fungus infections of the nails by using strong lithium bromide solutions.

Recently much attention has been paid to the catalyzing effect of copper in keratinization. Copper has a specifically enhancing effect on the disulfide closure (Figure 1). If sheep are fed a copper-deficient diet the wool is of poor quality because the keratogenous zone persists ten times longer than normal and the disulfide closure is delayed for several days. While this effect of copper is exerted directly on the keratinizing cells other factors influence keratinization indirectly by causing metaplasia in the germinative cells which in turn lead to modified keratinization. For instance, estrogens enhance keratinization and desquamation by promoting epithelial proliferation; excess vitamin A inhibits keratinization by tending to transform squamous stratified epithelium into a mucous membrane and, conversely, vitamin A deficiency produces excessive keratinization.

There is accumulation of glycogen in the

keratogenous zone. The accumulated glycogen, however, disappears with the onset of keratinization. The energy liberated by glycolysis is thought to be utilized for the disulfide closure.

In their overall chemical composition keratins differ from other proteins by their high sulfur content. This high sulfur content cannot be explained by the disulfide closure, because this closure does not change the absolute or relative amount of sulfur. The only possible explanation I can see is that amino acids which do not contain sulfur are split off from the keratinizing proteins. Actually, keratinized structures such as hair do contain large amounts and a great variety of free amino acids but none of those which contain sulfur, viz., methionine, cysteine and cystine. When amino acids which do not contain sulfur are split off, the percentage content of sulfur in the remaining protein will increase.

Studies in my laboratory have shown that on the keratinizing skin surface, in addition to the commonly occurring free amino acids, citrulline can be found regularly. Citrulline is an intermediate in the arginine cycle of Krebs and its presence on the skin surface indicates that the keratinizing cell operates this cycle.

Not only proteins but other cytoplasmic components are also split and decomposed during keratinizatin. Lipids are liberated from lipoproteins and appear on the surface. We were able to follow the decomposition of phospholipids during the keratinization process and found that after choline has been split off from the phospholipid molecule, choline itself is also decomposed.

The breakdown of the cell nucleus brings about liberation of pentoses and purines which can be recovered from hair extracts and from the skin surface.

A characteristic feature of the keratinizing cell is its dehydration. While the living cells which are going to keratinize contain an average of 70 per cent water, keratinized cells contain less than 20 per cent. In 1929 I pointed out that most of this water must be lost to the outside. In other words, one part of the cutaneous insensible water loss may originate from the keratinization process. Experiments in my laboratory have supported this assumption. While in acute inflammatory processes the insensible water loss is only slightly increased, if at all, it is augmented two to three times the normal values during the postinflammatory desquamation because the keratin production is accelerated. Whenever a pathologic process causes accelerated keratinization, as is the case in psoriasis and exfoliative dermatitis, the insensible water loss is increased up to ten fold. This is the reason that patients suffering from exfoliative dermatitis have continuous chills and drink excessive amounts of water without increasing their urinary volume.

In this presentation which deals with the physiology of keratinization I would like to mention only one of its anomalies because of its possible relationship to malignant degeneration.

Hair and nail are hard keratin structures which grow indefinitely without desquamating. In contrast, the thickness of the epidermal soft horny layer is constant in spite of continuous new formation of keratin because there is a continuous shedding of invisible tiny horn particles on the surface. Biochemical studies indicate that hard horn is more completely keratinized than soft horn. Under chronic irritative influences, however, the epidermal horny layer may become similar to hair and nail insofar as its shedding is decreased. A thicker and thicker horny layer piles up under the influence of pressure, rubbing, ultraviolet light irradiation and other physical and chemical agents if they act in a chronic fashion. Apparently, these agents modify the germinative epithelium, and the first sign of the change is that the germinative cells produce a harder, more completely keratinized horn than they should. This thickening of the horny layer under continued traumatization is the basis for the "hardening" of the skin that is seen in industrial dermatologic practice, namely an increasing resistance of the skin to physical and chemical injuries as the industrial worker continues performing the same job. In this sense, the thickening is a useful reaction. However, under special circumstances the same reaction can be the first manifestation of malignant anaplasia.

On the skin the precancerous keratoses are in most instances primarily caused by chronic ultraviolet light exposure. The very first sign of the premalignant change is a thickening

of the horny layer long before anaplastic changes appear in the living cells. Similarly, in leukoplakias of the mouth mucous membranes, the irritation by ragged edges of broken teeth, crowns, ill fitting dentures or the chemical stimulus of tobacco smoking first causes keratinization and piling-up of keratin on the otherwise not truly keratinizing mucous epithelium, before producing microscopically visible cellular anaplasia, malignant proliferation and invasion of the connective tissue.

Finally, I would like to point out that the hyperkeratinization reaction to chronic irritation of the skin is, in most cases, accompanied by a second common reaction, namely hyperpigmentation. It is worth while to note that these two reactions have some common features: both are associated with disappearance of sulfhydryl groups, both are catalyzed by copper and both can be regarded as defense reactions.

Physiology and biochemistry of cutaneous functions in man is a young branch of the clinical sciences. Application of physiological knowledge to problems of pathology and clinical medicine has just about started. It should be freely admitted that what I could tell you today about the keratinization process has had so far little if any repercussion on the practice of medicine in general and of dermatology in particular. Still, it is my conviction that this type of research will in the long run aid us most efficiently in our attempt to help our patients.

For references see Chapter 15, "Epidermal Proteins," and Chapter 16, "The Keratinization Process" in Rothman, S.: Physiology and Biochemistry of the Skin, University of Chicago Press, Chicago, 1954.

DISCUSSION

Dr. Mark H. Lepper: (Associate Professor of Medicine in Charge of Preventive Medicine) Have any of the sulfur containing amino acids been found on the skin?

Dr. Stephen Rothman: (Professor of Dermatology) No, so far, neither we or other workers found sulfur containing amino acids on the skin surface.

Dr. Ford K. Hick: (Professor of Medicine) Would you be kind enough to explain your technique for measuring insensible perspiration?

Dr. Rothman: We use glass bells with a glass hook inside the dome. Anhydrous calcium in linen bags are hung on the hook. The glass bell is fastened airtightly to the skin with tape for an exactly measured period of time. The weight increase of the bag containing calcium chloride is a measure of the insensible perspiration. For details on the method, I refer to the publication in J. Invest. Dermat., 6:271-278, 1945. We find this to be an extremely accurate technique, for if we compare symmetrical sides normally, we find less than 1% variation in the water delivery.

Dr. Z. Z Godlowski: (Research Associate in Medicine) Could you estimate the amount of protein lost in the process of keratinization?

Dr. Rothman: According to measurements and calculations of E. Voit in Germany a healthy adult young male has shed 116 gms. of keratin with the desquamating epidermis in one year.

Dr. Alexander Remenchik (Clinical Instructor in Medicine) There are at least two clinical conditions characterized by abnormalities in copper metabolism, hepatolenticular degeneration and nephrosis. Have you noted any disturbances in keratinization in these two clinical conditions?

Dr. Rothman: No, but I must confess no attention has been paid so far to any possible cutaneous disturbance in these conditions.

Oral and Injectible Chlorprophenpyridamine Maleate (Chlor-Trimeton® Maleate) in the Treatment of Pruritic Dermatoses

Rudolph S. Lackenbacher, M.D., Chicago

THE oral administration of antihistamines as adjunctive therapy for the relief of symptoms in various dermatological conditions has become well established. These compounds are now coming to be used parenterally because their prompt effect by this route is of benefit in many dermatitides.

Chlorprophenpyridamine maleate (Chlor-Trimeton® Maleate) orally has proved effective in various dermatitides, especially in relieving pruritus.[1–4] This substance in a solution for injection has reduced exudation in weeping eczemas and relieved pruritus or hives or both in urticaria and the dermal manifestations of drug allergy.[3,5] Following the reports of these effects, I adopted chlorprophenpyridamine maleate injection for use in conjunction with tablets of the drug orally in the treatment of pruritic dermatoses. It replaced a histamine-protein antigen complex that I formerly injected in these cases. This was done to obtain the prompt action of the parenterally administered drug and with the thought that the two forms of the antihistamine in combination might give a superior result.

CLINICAL STUDY

During the past six months, 216 patients with pruritic dermatoses were treated with a combination of Chlor-Trimeton repeat action tablets** and Chlor-Trimeton in injectible solution** as adjuncts to local therapy. The prolonged action tablets contained 4 mg. chlorprophenpyridamine maleate in the tablet coating and 4 mg. in the tablet core. As the drug in the coating was available for an immediate effect and that in the center of the tablet was coated to delay its release for about four hours, a sustained antihistaminic effect was obtained. The aqueous injectible solution contained 100 mg. chlorprophenpyridamine maleate in each cubic centimeter. Because of the potency of the drug on a milligram basis, this high concentration made it possible to use small doses.

The conditions treated and the number of patients with each were as follows: circumscribed neurodermatitis 23, disseminated neurodermatitis 14, contact dermatitis 148, dermatitis or pruritus anogenitalis 16, acute or chronic urticaria 6, miscellaneous pruritic dermatoses 9. Some conditions were of long standing, for example, cases of circumscribed neurodermatitis of two and six years' duration, atopic dermatitis of 16 months' duration, and contact dermatitis of two to six months' duration. Some had been unresponsive to other treatment.

The plan of therapy included a search in each instance for etiologic factors and an attempt to eliminate offending agents. Patients were instructed as to proper diet. They were advised to rest and relax as much as possible in order to remain free of tension. An effort was made to keep their environments quiet and conducive to the healing of skin disease.

At the initial visit, each patient received subcutaneously or intramuscularly 10 mg. (0.1 cc.) chlorprophenpyridamine maleate injection. This dose was repeated at each weekly visit. In the case of patients with weeping dermatoses or urticaria, injections of 10 mg. chlorprophenpyridamine maleate were made twice weekly until the desired response had been obtained. Injections totaled 820 in the entire series.

During the interval between the injections of antihistamine, each patient was directed to take each day one 8 mg. repeat action chlorprophenpyridamine maleate tablet after breakfast and

---

Attending Dermatologist, Columbus Hospital and Frank Cuneo Hospital, Chicago.

Presented before the Metropolitan Dermatological Society of Chicago, November 10, 1954.

**Manufactured by Schering Corporation, Bloomfield, New Jersey.

upon retiring. A few patients required three tablets daily. When itching was severe enough to disturb sleep, an 8 mg. repeat action tablet of chlorprophenpyridamine maleate also containing 3/4 grain sodium pentobarbital was taken at bedtime in place of the plain antihistamine tablet.

Locally, patients applied as needed an ointment composed of 40 Gm. boric acid solution 3%, 40 Gm. lanolin or Aquaphor, and white petrolatum to make 100 Gm. In conditions accompanied by exudation, wet dressings of 3% boric acid or 1:20 Burow's solution were used.

RESULTS OF TREATMENT

Itching was promptly relieved in most of the patients soon after injection of the antihistamine. This occurred even in some severe cases of acute and chronic urticaria. The administration of the prolonged action chlorprophenpyridamine maleate tablets maintained the effect so that the patients remained comfortable. Exudation decreased rapidly. Symptomatic relief became apparent in this series of patients, especially in cases of contact dermatitis, circumscribed neurodermatitis, urticaria, and dermatitis and pruritus anogenitalis, sooner than it had when only the tablet form of the antihistamine had been used.[4]

With the symptoms held in check, a search for the etiologic factors in the conditions under treatment could be initiated. The elimination of itching with control of the urge to scratch and the reduction in exudation facilitated involution of the dermatologic lesions. With these effects and the use of local applications, inflammation when present subsided. Improvement in the primary condition usually occurred rapidly. In all, 162 (75 per cent) of the patients improved satisfactorily. A moderate degree of improvement occurred in 42 (19.4 per cent) Twelve could not be followed adequately to evaluate the results of treatment.

No drowsiness or serious side actions to chlorprophenpyridamine maleate occurred. Occasional slight burning at the site of injection of the antihistamine solution ceased after three to five minutes.

PROPHYLAXIS OF PENICILLIN REACTIONS

Chlorprophenpyridamine maleate parenterally has been reported to be highly effective in preventing allergic reactions to penicillin.[6-8] Therefore, the solution containing 100 mg. of this antihistamine per cubic centimeter was used prophylactically in 10 patients receiving 37 injections of penicillin. Three of the group had previously exhibited sensitivity reactions to penicillin. Ten milligrams (0.1 cc.) chlorprophenpyridamine maleate were injected intramuscularly immediately after the injection of each dose of penicillin. No hypersensitivity reactions to the antibiotic occurred. The 3 known reactors were completely protected from reactions by this treatment.

CONCLUSIONS

Chlorprophenpyridamine maleate injection and repeat action tablets used in combination give prompt and sustained symptomatic relief in pruritic dermatoses as shown by the elimination of itching and reduction of exudation in 216 patients. The relief of symptoms facilitates the search for etiologic factors and the healing of dermatologic lesions treated with local applications.

Chlorprophenpyridamine maleate injected intramuscularly concomitantly with injection of penicillin may prevent sensitivity reactions to this antibiotic. Ten patients, including 3 known reactors, were completely protected from penicillin reactions by a dose of 10 mg. (0.1 cc.).

4753 Broadway

BIBLIOGRAPHY

1. Allison, J. R., and Robinson, A. M.: A new antihistamine-Chlor-Trimeton Maleate, South Carolina M. A. **45**:344, 1949.
2. Eisenstadt, W. S.: A clinical evaluation of Chlor-Trimeton, Journal-Lancet **70**:26, 1950.
3. Bernstein, C., and Klotz, S. D.: The use of Chlor-Trimeton in allergic diseases with special reference to its injectible administration, Ann. Allergy **10**:479, 1952.
4. Lackenbacher, R. S.: Chlor-Trimeton repeat action tablets in the treatment of pruritic dermatoses, Ann. Allergy **10**: 765, 1952.
5. Jenkins, C. M.: A small dosage injectible antihistamine (Chlor-Trimeton Maleate Injectable) in the treatment of allergic diseases, Ann. Allergy **11**:96, 1953.
6. Maslansky, L., and Sanger, M. D.: A method of decreasing penicillin sensitivity, Antibiotics & Chemother. **2**:385, 1952.
7. Sanger, M. D.: Maslansky, L.; Rapaport, H. G.; Grosberg, S., and Peshkin, M. M.: Combined allergen-Chlor-Trimeton desensitization by injection, Ann. Allergy **11**:354, 1953.
8. Beck, C. A.: Subacute bacterial endocarditis in penicillin-sensitive patient, J.A.M.A. **153**:1170, 1953.

EDITORIALS

Education versus service

Many hospitals in Illinois do not have their quota of interns; some have none at all. This situation is not peculiar to our state; it is nation wide. One reason is that there are 3,000 more approved internships than there are interns to fill them.

Competition is keen yet some hospitals are successful year after year in filling their rosters. What is their secret? The report of the Advisory Committee on Internships to the Council on Medical Education and Hospitals may offer a clew. The report states:

"When an attending staff realizes that teaching takes time worth dollars in the office, when the staff cherishes the continuously broadening viewpoint that comes from day after day of give and take with interns, the intern roster usually is overfilled, although paint may peel from the walls of the living quarters and stipends be nominal. For such a staff spirit can so illuminate bedside teaching that the interns' progress toward clinical maturity through supervised, graded responsibility is assured. No tennis courts, television sets, kitchenette apartments, or printed lists of conference can substitute for this spirit in giving an intern a feeling of function.

The more famous and widely sought after municipal or county services in this country cannot always be distinguished from less popular services by ward equipment, house staff pay, or indeed by laboratory buildings. They can be distinguished by the freedom and content of communication among the little knots of men and women who serve the wards, operating rooms, autopsy rooms, and laboratories regularly, day after day. On the other hand, we are all acquainted with hospitals which, despite superb physical plants and high stipends, are not always successful in attracting an intern staff. Some of these are private hospitals; a few have large public wards."

Hospitals meeting these qualifications are few and far between. Nevertheless, this type of institution attracts the more mature graduate who appreciates the need for continued study and the benefits to be derived from associating with a staff "who have remained students of medicine."

But many students will settle for less. Those who are in debt or have a growing family to support may select the place offering the most money or the closest to home. Interns who are influenced by the social trends that began in the Roosevelt regimen expect to be spoon-fed. For them, the living quarters, number of nights off, and the 9 a.m. to 5 p.m. working schedule are of the utmost importance. They are convinced that hospitals exploit interns and should pay for services rendered.

Between these extremes are the majority of seniors who want to intern in a hospital that offers an education as well as a place to care for the sick. They are willing to render service, provided the staff reciprocates with bedside instruction and constructive criticism. Good patient care and education go hand in hand and the attending physician who expects service without giving instruction is as off the beam as the intern who expects education on a 9 to 5 basis.

From the intern's point of view, the attending physician who is too busy to instruct is of little value to him even though highly skilled in the



F. Garm Norbury, M.D.

President, Illinois State Medical Society

1955 — 1956

practice of medicine. Hospitals so staffed may have an excellent reputation in the community but they never seem to attract interns.

How can the situation be remedied? The cooperation of the staff is vital. Unless the busy man is willing to take time to teach, additions to the staff may be needed. This would provide an excellent opportunity to add younger men willing to spend part of their time with the interns in the hospital.

‹ ›

Report on your 1955 Annual Meeting

The 1955 Annual Meeting of the Illinois State Medical Society was held at the Hotel Sherman, Chicago, on May 17-20. The hotel was completely filled which shows the value of procuring hotel accommodations early for those attending the meeting. As usual, the exhibits and scientific meetings were presented on the mezzanine and the first floor of the hotel.

The Public Relations dinner meeting on Tuesday evening was well attended and a fine program of general interest was presented. The Annual Dinner on Wednesday evening likewise was a most important function and it too, was well attended. There were approximately 150 present for the Annual Luncheon Meeting of the Fifty Year Club, which once more was presided over by the Chairman, Andy Hall, of Mt Vernon, a young man who has practiced 65 years, and is still in his office daily.

It was interesting to note that several present on this occasion, were physicians who have retired, and who came from Florida, California, and several other states to be on hand for the Fifty Year Club Luncheon. Recently a survey of the records show that this Society has presented more than 1,000 framed certificates and emblems to physicians in the Society who have completed fifty years of practice. At least three were present on this occasion who had completed 65 years of practice.

At the closing session of the House of Delegates, Dr. F. Garm Norbury of Jacksonville, was inducted into the office of President by the retiring President, Dr. Arkell M. Vaughn of Chicago. Dr. F. Lee Stone, Chicago, was elected to the office of President-Elect, Dr. C. Elliott Bell, Decatur, First Vice President, Dr. Maurice M. Hoeltgen, Chicago, Second Vice President, and Dr. Harold M. Camp, Monmouth, re-elected as Secretary-Treasurer.

Drs. Carl E. Clark, Sycamore, and Joseph T. O'Neill, Ottawa, were re-elected as members of the Council to succeed themselves. Drs. E. A. Piszczek and Edwin S. Hamilton were were also re-elected as Council members. The Council later elected Joseph T. O'Neill to succeed himself for another year as Chairman of the Council. Dr. Caesar Portes, Chicago, was elected as a member of the Council to succeed Dr. F. Lee Stone who had been advanced to the office of President-Elect.

The following were elected as Delegates to the American Medical Association for a two year term, beginning January 1, 1956. H. Kenneth Scatliff, Chicago, Walter C. Bornemeier, Chicago, J. Mather Pfeiffenberger, Alton, Harlan English, Danville, Everett P. Coleman, Canton.

Alternate Delegates to the A.M.A. elected for two years; Eugene T. McEnery, Chicago, Frank H. Fowler, Chicago, A. F. Goodyear, Decatur, Lester S. Reavley, Sterling, Edward H. Weld, Rockford.

The total registration for the meeting, was approximately 3,500, of which more than 2,000 were members of the Society. The meetings for 1956 and 1957 had previously been set for Chicago, and it was also voted to hold the 1958 meeting in Chicago.

The 1955 Annual meeting was a most successful one, and the House of Delegates at the closing session instructed the Secretary to thank all of those who were responsible for the many arrangements and those who aided materially in insuring a successful meeting.

‹ ›

Your President-Elect.

At the closing session of the House of Delegates of the Illinois State Medical Society held May 20, Dr. F. Lee Stone of Chicago, was elected to the office of President-Elect. He will assume the office of President on the last day of the Annual Meeting in May, 1956.

Dr. Stone was born in St. Louis, Missouri, and at the age of six months, the family moved to Byron, Illinois. After a short stay there, they moved to Chicago. He attended grammer school and was graduated from high school in Chicago. He entered the University of Illinois School of Medicine and was graduated in 1910. He spent

two years as an intern at the Cook County Hospital, then located at Beaver Crossing, Nebraska. After getting two years of experience as a general practitioner, Dr. Stone came to Chicago to prepare himself for a career in obstetrics and gynecology.

He has been a member of the staff of the Henrotin Hospital in Chicago for the past 41 years. Since 1941 he has been senior gynecologist at the hospital. He was associate professor of obstetrics and gynecology at the University of Illinois School of Medicine for many years, and now holds the designation of associate professor emeritus in that department.

He enlisted in the Army Medical Corps for the first world war, and served in France for 20 months, associated with Base Hospital #36 and Ambulance Company, 165. Dr. Stone has been a member of the Council of the Illinois State Medical Society for a number of years and for two years was Chairman of the Council. He holds membership in the Chicago Medical Society, Illinois State Medical Society, and the American Medical Association. He is a Past President of the North Side Branch of the C.M.S. He likewise is a member of a number of other medical and surgical societies.

In 1913, he was married to Dena McRae, of Rhinelander, Wisconsin and they are parents of two sons and one daughter. Dr. and Mrs. Stone have five grandchildren. The son, Robert G. Stone graduated from the U. of I. School of Medicine in 1950. He served with the Armed Forces and has been taking a residency in obstetrics and gynecology at Detroit which will be completed in July, 1955, he plans to locate at Elmhurst, DuPage County.

Frank L. Stone, Jr., is now serving with the Armed Forces, and the daughter is Mrs. Arthur Kuss, and she resides in Chicago. Dr. Stone received his Masonic degrees while practicing in Nebraska, and he is a member of the Scottish Rite Bodies and of Medinah Shrine Temple in Chicago. He is also a member of the Rotary Club, the Chicago Athletic Association and Veterans of Foreign Wars.

The House of Delegates of the Illinois State Medical Society was wise in the selection of Dr. Stone for the office of President-Elect, and he will faithfully carry on the duties of that office, as well as the office of President next year. He is already well known by many of the members of the Illinois State Medical Society, and he expects to greet many more of the membership in their respective home communities during the next two years.

‹ ›

The A. M. A. Annual Meeting

The 1955 Annual Meeting of the American Medical Association was held in Atlantic City, New Jersey, June 6-10. The meeting was well attended although with two stormy days, the attendance may have been curtailed somewhat. The physician attendance was approximately 12,000 and the overall attendance about 27,000. The Illinois physicians registered at the meeting totalled about 400, with all sections of the state represented.

Technical and Scientific Exhibits, as well as most of the scientific programs were conducted in the large Convention Hall on the board walk. This was a very busy place throughout the entire session. The meetings of the House of Delegates were held in the American Room of the Hotel Traymore. Some 85 resolutions were introduced and reviewed by a number of reference committees, then the report of the respective committees were referred back to the House for action.

The Reference Committee meetings were attended by large numbers of delegates and members of the A.M.A., as there were quite a few controversial subjects brought before the committees. These reports will be published in issues of the Journal of the American Medical Association in the near future, and reference will be made here, only to some of the most important controversial reports.

The House of Delegates on Thursday, June 9, approved the following recommendations made by the Reference Committee on Medical Education and Hospitals, filed as a "minority report"

(1) That the report of the Committee for the Study of Relations between Osteopathy and Medicine (chairman, Dr. John Cline of California), be received and filed; and that the Committee be thanked for its diligent work, and be discontinued.

(2) That if and when the House of Delegates of the American Osteopathic Association, their official policy-making body, may voluntarily abandon the commonly so-called "osteopathic

concept", with proper deletion of said "osteopathic concept" from catalogs of their colleges; and may approach the Trustees of the American Medical Association with a request for further discussion of relations of Osteopathy and Medicine, then the said Trustees shall appoint another special committee for such discussion."

Milford O. Rouse, M.D., (Dallas, Texas) member of the Reference Committee on Medical Education and Hospitals, who signed the report, closed with the following quotation from the Oath of Hippocrates:

". . . . . and that by precept, lecture and every other mode of instruction, I will impart a knowledge of the Art to my own sons and to those of my teachers, and to disciples bound by the stipulation and oath, ACCORDING TO THE LAW OF MEDICINE, BUT TO NONE OTHERS. . . ."

ILLINOIS MEN AND THE HOUSE OF DELEGATES

On the Reference Committees of the House of Delegates:

(1) Amendments to the Constitution and Bylaws: member of Committee — Percy E. Hopkins

(2) Committee on Credentials — Harlan English, chairman

(3) Miscellaneous Business — member of the Committee, Everett P. Coleman

(4) Rules and Order of Business, member of the Committee, Charles H. Phifer

On Thursday when the elections were held:

(1) Harlan English, Danville was elected to a five year term on the Council on Medical Education and Hospitals.

(2) Warren W. Furey, Chicago, was elected to serve the unexpired term until 1957, on the Council on Constitution and Bylaws.

The Illinois State Medical Society received an Award Of Merit presented by the American Medical Education Foundation "For outstanding contribution to the preservation and continuance of the high standards of medical education in the United States".

The award was accepted from Dr. Louis H. Bauer, President of the Foundation by Dr. F. Garm Norbury, President, and Dr. Harold M. Camp, Secretary, of the Illinois State Medical Society, before the House of Delegates.

SCIENTIFIC EXHIBIT AWARDS

The Silver Medal (Billings Medal Winners for exhibits which do not exemplify purely experimental studies but are judged on the basis of excellence of correlating facts and excellence of presentation) went to: B. M. Gasul, E. H. Fell, H. G. Bucheleres, C. J. Marienfeld, Gershon Hait, R. F. Dillon, P. G. Szanto and Maurice Lev, The Hektoen Institute for Medical Research, Cook County Children's Hospital, Presbyterian Hospital, and the University of Illinois College of Medicine, Chicago — for the exhibit in normal and abnormal heart.

Dr. Dwight H. Murray, Napa, California, former Chairman of the Board of Trustees, was elected President-Elect at the closing session of the House on Thursday afternoon. Dr. Millard D. Hill, Rawleigh, N. C., was elected Vice President, Dr. Goerge F. Lull of Chicago, re-elected as Secretary and Dr. Josiah J. Moore, Chicago, re-elected as Treasurer. Dr. Gunner Gunderson, La Crosse, Wisconsin was elected as Chairman of the Board of Trustees, and Dr. James R. Reuling, Bayside, N. Y., elected to the Board of Trustees to succeed Dr. Murray. Drs. Thomas P. Murdock, Meriden, Connecticut, and Leonard W. Larson of Bismarck, N. D. were elected to succeed themselves as members of the Board.

Dr. E. Vincent Askey, of Los Angeles, and Dr. Louis M. Orr, Orlando, Florida, were elected as Speaker and Vice Speaker of the House of Delegates.

Even though the A.M.A. House of Delegates holds two meetings each year, there is always enough business for action of the House to justify two annual meetings, as was well illustrated at this Atlantic City meeting.

‹ ›

"Volume II"

The History Committee was created by the Council in August 1947. Except for the continuing interest of the Council Volume II would not have been completed. The interest is especially noteworthy for only four men who were members of the Council in 1947 are now members of that body.

Probably no one, with the possible exception of Dr. D. J. Davis, the editor, had any idea of the length of time it would take to collect the material. It took almost exactly seven years to get the manuscripts into the hands of Dr. Davis.

A few interesting items about the publishing

of the book: If one feels that the number 13 is a lucky one, the large sale of the book, which the Committee earnestly seeks, is assured.

R. R. Donnelley & Sons Company, who printed the book, received the manuscript the latter part of October 1954. Their work proceeded rapidly. Dr. Davis had already read several chapters of galley proof before his sudden death December 19. However, the making of the index was complicated due largely, it appears, to the number of contributors. So as a consequence by early April it appeared doubtful whether the book could be delivered in time for the annual meeting in May 1955. Mr. Walter M. Sackett, Mr. Paul Barton and Mr. Albert H. Schlag of Donnelley's went out of their way to hasten its completion. April 8, 1955 Mr. Barton phoned that the page proofs of the index would arrive in Chicago the morning of April 13; if corrections could be made and telephoned to Crawfordsville, Indiana, where the book was being printed, by 4.00 P.M. that day, the book would be delivered in Chicago by Friday May 13. Miss Ella M. Salmonsen and Mrs. Louise B. Searing set aside April 13 for the correction of the index and the book was delivered on Friday May 13.

The last report to the House of Delegates was Item 13 on the agenda for that day. The chairman of the Committee asked to announce the book to the Society of Internal Medicine on May 23 and found himself seated at table 13. Whether this concatenation of thirteens is a good omen remains to be seen.

The volume is a book of 509 pages, consisting of 25 chapters written by 32 contributors. It tells the story of our own profession, from 1850 to 1900—a story both interesting and helpful to each of us — a valuable reference work.

The Committee hopes that every member of the Society will secure a copy of Volume II of "The History of Medical Practice in Illinois."

Traffic safety

Practically all of us look forward to Friday because to most of us it means that another weekend has arrived. The weekend is a time for pleasure and relaxation. There's that tennis game we had planned, a picnic with the family, and perhaps a golf game with our next door neighbor. It's the time for going to church, fixing things around the house, cleaning out the attic, and watching television.

The weekends are all of those things — except on the highways. In 1954, 13,980 persons were killed and 678,000 were injured in weekend accidents, according to figures compiled and released by The Travelers Insurance Company. Thirty-nine per cent of the deaths and 35 per cent of the injuries were recorded on Saturdays and Sundays in 1954.

The most dangerous day of the week for driving is Saturday. One good reason is that more cars are traveling the highways on Saturdays than on any day. There is another important feature which sets this day apart from the others. For too many people, Saturday night is a time when drinking and driving are combined.

No one knows how many traffic accidents are caused by drinking drivers, but everyone knows it is a major problem.

For example, walk into your traffic courts any day and you will find them crowded with persons who were involved in serious accidents as a result of drinking. Everyone needs to know that even one drink before driving is too many. We saw an advertisement the other day which said: "If You Drive — Don't Drink — If You Drink — Don't Drive." This sounds like very simple advice, but it makes a great deal of sense.

Weekends should indeed be happy ones for everyone. Let's try and make it that way.

CORRESPONDENCE

Clinics for crippled children listed for August

Nineteen clinics for Illinois' physically handicapped children have been scheduled for August by the University of Illinois Division of Services for Crippled Children. The Division will count 13 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social and nursing service. There will be 5 special clinics for children with rheumatic fever and 1 for cerebral palsied children.

Clinics are held by the Division in cooperation with local medical and health organizations, both public and private. Clinicians are selected among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or may want to receive consultative services.

The August clinics are:

August 2 — Macomb, Marietta Phelps Hospital

August 3 — Hinsdale, Hinsdale Sanitarium

August 4 — Effingham, St. Anthony's School Gymnasium

August 4 — Litchfield, Madison Park School

August 9 — Peoria, Children's Hospital

August 9 — E. St. Louis, Christian Welfare Hospital

August 11 — Springfield, St. John's Hospital

August 11 — Elmhurst (Rheumatic Fever), Memorial Hospital of DuPage County

August 11 — Tuscola, Veterans of Foreign Wars Building

August 12 — Chicago Heights (Rheumatic Fever), St. James Hospital

August 17 — Alton (Rheumatic Fever), Alton Memorial Hospital

August 17 — Chicago Heights, St. James Hospital

August 18 — Rockford, St. Anthony's Hospital

August 23 — Peoria, Children's Hospital

August 23 — Effingham (Rheumatic Fever), St. Anthony's Hospital

August 24 — Springfield (Cerebral Palsy), Memorial Hospital

August 24 — Elgin, Sherman Hospital

August 25 — Bloomington, A.M. (General), P.M. (Cerebral Palsy), St. Joseph's Hospital

August 26 — Chicago Heights (Rheumatic Fever), St. James Hospital

‹ ›

Illinois Association Of Medical Health Officers

During the Illinois State Medical Society Convention in Chicago, the Illinois Association of Medical Health Officers had their regular annual meeting. This is an Association of all the Physicians in the State who are full time, qualified, Medical Health Officers.

Dr. John B. Hall, Director of the Cook County Department of Public Health was elected President and Doctor Herbert Ratner, Health Commissioner of the Village of Oak Park was elected as President-Elect of the organization. Dr. N. R. Frankovelgia, Health Director of the Stickney Township Health Department and the Berwyn Township Health Department was elected Secretary-Treasurer. These officers assumed their positions at the regular meeting on May 19th.

NEWS of the STATE



ADAMS

Fifty Year Certificates.—Drs. H. R. Folckemer and O. F. Shulion, both of Quincy, were inducted into the Fifty Year Club of the Illinois State Medical Society, April 11, when they were presented with the certificate and pin emblematic of this honor. Presentation was made by Dr. Warner H. Newcomb, Jacksonville, Councilor of the Sixth District at a meeting of the Adams County Medical Society. Dr. Shulion was inducted into the Club in absentia. Guest speaker was Dr. Edward I. Kraft, chief of anesthesia, St. Luke's Hospital, St. Louis, who talked on the use of the various anesthetics and some of their complications.

COOK

Carl Moore Honored.—Carl R. Moore, professor and chairman of the department of zoology, University of Chicago, has been given the first medal to be awarded by the Endocrine Society. The medal has been established to honor distinguished scientific research in the study of the endocrine glands. Moore is one of the pioneers in the study of sex glands and hormones.

Michael Reese Alumni Choose Officers.—At the annual alumni banquet of the Michael Reese Hospital Alumni Association in Chicago recently, Dr. Siegfried Strauss, senior attending physician in the department of surgery, was elected president, succeeding Dr. Theodore M. Shapira. Dr. Sam Behr, Rockford, was named to succeed Dr. Herman Smith, Des Moines, as vice president. Dr. Bernard Cohen, associate attending physician in the department of otorhinolaryngology at Michael Reese, was reelected secretary, and Dr. Gerald J. Menaker, adjunct attending physician in the department of surgery was reelected treasurer.

Grant to Chicago Medical School.—The Chicago Medical School has received a grant of $2,000 from the Sidney Hillman Foundation. The foundation, which was established on the death of the noted labor leader by the Amalgamated Clothing Workers of America, each year makes grants to educational and welfare institutions and makes awards recognizing outstanding contributions to public life in America.

Public Health Service Grants.—Eight Northwestern University scientists have received Public Health Service research grants totaling $77,000. Largest grants were for rheumatic fever research. Drs. Eugene L. Hess and Hutton D. Slade, research associates of the Rheumatic Fever Research Institute, were awarded $27,000 to study streptococcus hemolyticus and its role in causing rheumatic fever. Dr. Richard Schayer, also an Institute research associate, was given $15,000 to study allergy and inflammation. Other grants went to Dr. Jules H. Last, assistant professor in medicine, for research in the diagnosis of coronary heart disease, and to Dr. Samuel Feinberg, professor of medicine and director of the allergy research laboratory, for a study of the effects of stress on allergies and hypersensitivity. The development of physical and mental fatigue will be studied by Dr. Carl P. Duncan, associate professor of psychology. Dr. Fred Basolo, associate professor of chemistry, and Henry M. Neumann, assistant professor, will study the dissociation and optical properties of complex chemical ions.

Personal.—Dr. Paul C. Bucy, professor of surgery, Northwestern University Medical School, received a Distinguished Service Award from the University of Chicago School of Medicine at the annual alumni dinner, of the Medical Alumni Association June 9.

Illinois Graduates.—Almost 400 students received degrees in the health sciences at University of Illinois Professional Colleges' commencement at 10:30 a.m. Friday, June 17, in Medina Temple. Dr. Robert A. Moore, vice chancellor of the University of Pittsburgh Schools of the Health Professions, de-

livered the commencement address on "Health Care in the Future." President Lloyd Morey conferred the degrees, about 20 more than last year. Degrees were doctor of medicine, 134; doctor of dental surgery, 67; bachelor of science in pharmacy, 79; bachelor of science in occupational therapy, 14; bachelor of science in nursing, 25; doctor of philosophy, 11; and master of science, 29. Four students receiving M.D.'s also received master of science diplomas.

Clinical Laboratories Move.—Drs. Harold A. Grimm and Coye C. Mason announce the removal of their clinical laboratories to 2056 North Clark Street, Chicago 14. Practice will be by referral only and will be limited to pathologic anatomy and clinical pathology. The telephone number is Lincoln 9-1619.

Northwestern News.—Recent news about faculty members of Northwestern University include the following: Dr. Loyal Davis, chairman of the department of surgery, has been awarded an honorary fellowship by the Royal College of Surgeons. According to a news release, only one other Chicago surgeon has ever been given the honor. He was the late Dr. John B. Murphy, who died in 1916 and who was once chairman of the department of surgery at Northwestern. Dr. Richard W. Tiecke, formerly deputy chief of the oral pathology branch of the Armed Forces Institute of Pathology, Washington, D. C., has been appointed associate professor of pathology. Besides doing research in oral cancer and teaching at the dental school, Dr. Tiecke will serve on the consulting staffs of several Chicago hospitals affiliated with the university.

Society News.—Dr. Raymond W. McNealy, associate professor of surgery, emeritus, Northwestern University Medical School, recently presented the following lectures: Middle East Medical Assembly of the American University of Beirut, Beirut, Lebanon, April 22, on "Resection of the Large Bowel with Primary Anastomosis" and "Tumors of the Parotid Gland"; Faculty of Medicine of the University of Istanbul, Istanbul, Turkey, April 27, "Newer Concepts of Large Bowel Surgery"; Royal Society of Medicine, London, England, May 17, on "Diverticulitis of the Colon", and International College of Surgeons at Geneva, Switzerland, May 25, on "Parotid Gland Tumors."

Special Society Elections.—Dr. Maxwell P. Borovsky, professor and chairman of the department of pediatrics at the Chicago Medical School, has been elected president of the Chicago Pediatric Society.—New officers of the Chicago Orthopaedic Society are Drs. Clinton Compere, president-elect; John Fahey, president; George Garceau, vice president; Newton Mead, secretary-treasurer, and William Larmon, assistant secretary.—At a meeting of the Chicago Neurological Society in May, Dr. Adrien Ver Brugghen was elected president; Dr. Irving Sherman, vice president; Dr. Benjamin Boshes, Councilor, and Dr. Oscar Sugar, secretary. —Dr. Bernard Stodsky, Chicago, was recently chosen president-elect of the Illinois Society of Anesthesiologists; other officers are Drs. William O. McQuiston, Peoria, president; James A. Felts, Marion, vice president; Ernest F. Kreutzer, Joliet, secretary; Herman J. Nebel, East St. Louis, delegate, and E. M. Dewhirst, Danville, and Edward V. Platt, Rockford, alternates. Dr. Morris J. Finer, Brookfield, continues as treasurer.—At a recent meeting of the Chicago Society of Physical Medicine and Rehabilitation, Dr. Joseph Koczur was named president; Dr. Gusta Davidson, vice president and chairman of the program committee, and Dr. Ralph E. DeForest, secretary-treasurer.—Dr. Arthur R. Colwell has been named president of the Chicago Society of Internal Medicine; Dr. Fred E. Ball, vice president, and Dr. Franklin A. Kyser, secretary.—At a meeting of the Chicago Urological Society recently, Dr. Joseph H. Kiefer was named president; Dr. Knowlton E. Barber, vice president, and Dr. Don E. Murrary, secretary-treasurer.

Lectures Honor Memory of Rollin Woodyatt.—The first in a series of annual lectures in memory of Dr. Rollin Turner Woodyatt, internationally known Chicago physician, medical teacher, and investigator, was given under the auspices of Northwestern University Medical School on Friday May 20, in Thorne hall.

Dr. Evarts A. Graham, emeritus professor of surgery at Washington University, St. Louis, Mo., spoke on the latest developments in clinical surgery.

Dr. Graham, chosen to give the first of the memorial lectures, formerly lived in Chicago where he was a close friend and colleague of Dr. Woodyatt. Until recently he was chairman of the board of regents of the American College of Surgeons. He is best known for having developed the Graham-Cole method for studying the gall bladder by X-ray, for his pioneer work on the relationship of smoking to cancer, and for his eminence as a medical teacher.

Dr. Woodyatt died in Chicago in 1953 at the age of 75. He devoted his professional life to the study of diabetes and was well-known for his achievements in the care of diabetic patients. He also was noted for research in the field of metabolism and as a devoted teacher. He played an important part in the development of several national medical organizations.

Dr. Woodyatt practiced, taught, and conducted research at Presbyterian hospital in Chicago where he became famous for devising new apparatus and developing new methods for treatment of disease.

He was head of the department of medicine at Rush Medical College, was president of the Institute of Medicine in Chicago, president of the American

Society for Clinical Investigation, president of the Association of American Physicians, and director of the Sprague Memorial Institute Laboratory for Medical Research.

According to Dr. Arthur R. Colwell, chairman of the department of medicine at Northwestern University Medical School and close associate of Dr. Woodyatt for many years, "Rollin Woodyatt's monuments are scattered all over the country and the world, chiefly as physicians who have been influenced by his ideals and as the fruits of his research investigations."

DU PAGE

George Schroeder Honored.—The insignia of the Fifty Year Club of the Illinois State Medical Society was presented to Dr. George Schroeder, Itasca, at the May 25 meeting of the DuPage County Medical Society. Presentation of the certificate and pin was made by Dr. Edwin S. Hamilton, Kankakee, Councilor of the Eleventh District. Dr. Schroeder graduated at the Northwestern University College of Pharmacy in 1898 and at the university's medical school in 1905. After practicing medicine in Chicago



Dr. George Schroeder and Dr. Edwin S. Hamilton

for one year, Dr. Schroeder moved to Itasca where he has been engaged in active practice forty-nine years. He served as village trustee for eight years and as village president for twelve years. Dr. and Mrs. Schroeder will observe their golden wedding anniversary next year.

In addition to Dr. Schroeder, the DuPage County Medical Society has three other living fifty Year Club members: Drs. E. W. Marquardt, Elmhurst; E. H. Oelke, Wheaton, and Henry F. Langhorst, who has retired and is now living in Florida.

At the meeting honoring Dr. Schroeder, the DuPage County Medical Society was the guest of the Argonne National Laboratory. Speakers were Andrew F. Stehney, Ph.D., on "Human Intake and Retention of Radium Under Natural Conditions"; Harry Auerbach, M.P.H., "Geographical Distribution of Bone Tumors in Illinois, and Mirian Finkel, Ph.D., "Experimental Approach to Permissible Levels of Internal Emitters." Asher J. Finkel, M.D., presented the summary.

ROCK ISLAND

New Officers.—Dr. L. J. McCormick, Moline, chief of the medical staff of the Farmall Works of International Harvester Company, Rock Island, has been installed as president of the Rock Island County Medical Society and Dr. M. F. Weisman named president-elect. Other officers are Drs. Frederick L. Eihl, Moline, first vice president; C. P. O'Neill, Rock Island, second vice president; George A. Cook, East Moline, reelected secretary; Phoebe Pearsall, Moline, treasurer, and S. Errico, Moline, censor.

ST. CLAIR

Otto Knewitz Honored.—Dr. Otto W. Knewitz, East St. Louis, a graduate of Washington University School of Medicine, St. Louis, was inducted into the Fifty Year Club of the Illinois State Medical Society. The certificate and pin, emblematic of the honor, were presented to Dr. Knewitz at a meeting of the St. Clair County Medical Society at the St. Clair Country Club, June 9. The society was addressed recently by Drs. Don C. Weir and W. S. Broker on "Valuation of Accuracy in Roentgenological Diagnosis."

SANGAMON

Fifty Year Club Member.—Dr. Harrison C. Blankmeyer, Springfield, was inducted into the Fifty Year Club of the Illinois State Medical Society at a recent dinner meeting of the Sangamon County Medical Society. Dr. Jacob E. Reisch, Councilor of the Fifth District, made the presentation of the certificate and pin. The Bulletin of the Sangamon County Medical Society notes that the society now has thirteen living members of the Fifty Year Club. Dr. Blankmeyer received his degree in pharmacy from Ohio Northern University and his M.D. from Northwestern University Medical School in 1905. Prior to entering medical school, Dr. Blankmeyer served at Fort Thomas, Kentucky, during the Spanish-American War, then re-enlisted for three years, serving as pharmacist aboard the U. S. Hospital Ship, Relief. He has been a member of the Sangamon County Medical Society since 1906.

New Commission of Health.—Dr. J. A. Lindquist has been appointed commissioner of health of Springfield, succeeding Dr. J. Marvin Salzman who recently resigned. The Sangamon County Medical Society, in a resolution commending Dr. Salzman for his work in the office, urged that he withdraw his resignation.

Dr. Lindquist previously served as superintendent of health from 1943 to 1947.

Society News.—"What Not to Do in Gynecology" was the subject of Dr. George B. Bradburn before the Sangamon County Medical Society. Dr. Bradburn is associate professor of obstetrics and gynecology at Northwestern University Medical School.

VERMILION

Society News.—At a meeting of the Vermilion County Medical Society recently, Dr. Robert A. Schimek, associate ophthalmologist, Henry Ford Hospital, Detroit, spoke on "Recent Advances in Ophthalmology."

WINNEBAGO

New Quarters House Library.—The Winnebago County Medical Society now occupies space in the second floor of a building owned by Dr. Edward H. Weld at 308 North Wyman Street, Rockford. One of the noteworthy accomplishments of the project was the installation of the society's library in permanent quarters, marking the fulfillment of a dream of society members. The new quarters also house a snack bar, lounge, office for the executive secretary, Floyd Tarbert, and space for holding meetings.

GENERAL

Heart Disease Leads in Disbursements to Beneficiaries.—More than three fourths of the $367 million paid to the beneficiaries of deceased policyholders by the Metropolitan Life Insurance Company last year was for deaths from diseases of the heart and blood vessels or from cancer, it was reported by Frederic W. Ecker, the Metropolitan's president.

Diseases of the heart and blood vessels accounted for 56 percent of the payments, or $207 million. Twenty years ago the proportion paid out for these diseases was only 34 percent. Payments for cancer and allied conditions came to over $71 million, or about 19 percent of the total, which compares with 12 percent 20 years ago.

"The increase in the proportion of disbursements for these two groups of diseases reflects largely the reduction in mortality from the infectious diseases, such as pneumonia and tuberculosis," Mr. Ecker commented. "In view of the importance of the heart disease problem the Metropolitan, with other insurance companies, has been financing research on cardiac diseases through the Life Insurance Medical Research Fund."

Somewhat over $600,000 was paid out by the Metropolitan in 1954 to the beneficiaries of policyholders who died from acute poliomyelitis. This was slightly less than the amount paid out in 1953.

One tenth of the total of last year's claim payments were for the external causes of death. Fatal accidents accounted for about $29 million, almost half of which was for motor vehicle accidents.

The total amount paid out in death claims during the year was the highest in the company's history, exceeding by $10,500,000 the payments in 1953, and by $214 million the amount paid 20 years ago.

This rise was the result, Mr. Ecker noted, of the growth in the number of persons insured and an increase in the amount of the average policy, since mortality rates in 1954 were generally lower than ever before.

"Your Doctor Speaks" over FM Station WFJL.—The following physicians have recently participated in the series "Your Doctor Speaks" over FM Station WFJL under the auspices of the **Educational Committee** of the **Illinois State Medical Society:**

Kenneth C. Johnston, assistant clinical professor in bronchoesophagology, department of otolaryngology, University of Illinois College of Medicine, on Foreign Bodies in the Air and Food Passages.

James R. Webster, professor of dermatology, Northwestern University Medical School, on Ringworm of the Scalp in Children.

Edward J. Brophy, attending pediatrician, Little Company of Mary Hospital, Periodic Health Supervision in Children.

Frederick W. Fitz, assistant professor of medicine, Northwestern University Medical School, The Regular Health Examination.

Alfred J. Kobak, professor and chairman of the department of obstetrics, Cook County Hospital Postgraduate School of Medicine, The Cesarean Section Story.

"All About Baby" on WGN-TV, Channel 9.—The following physicians have appeared on the telecast "All About Baby" on WGN-TV, Channel 9, under the auspices of the **Educational Committee** of the Illinois State Medical Society. The telecast, a Jules Power Production, features Ruth Crowley, R.N.

C. Jack Harrison, associate professor of pediatrics, Stritch School of Medicine of Loyola University, May 25, All About Speech.

John B. Hall, director, Cook County Department of Public Health, June 1, Poliomyelitis.

Ralph Spaeth, assistant professor of pediatrics, University of Illinois College of Medicine, June 8, on Rabies, Dog Bites, Pets for Baby.

Paul J. Cella, member of the pediatric staff, Little Company of Mary Hospital, June 15, on Hay fever.

Robert K. Hagan, instructor in pediatrics, Stritch School of Medicine of Loyola University, June 22, on Summer Mishaps.

Lectures Arranged Through the **Scientific Service Committee** of the **Illinois State Medical Society:**

John W. Payne, instructor in obstetrics and gyne-

cology, University of Illinois College of Medicine, Bureau County Medical Society at the Perry Memorial Hospital, Princeton, June 14, on Use of Hormones During Pregnancy.

J. Henry Heinen Jr., Chicago, certified by the American Board of Orthopedic Surgery, Whiteside-Lee County Medical Societies at Jul's Danish Farm, near Rock Falls, June 16, on Common Orthopedic Problems.

‹ ›

DEATHS

Harvey S. Allen*, Chicago, who graduated at Northwestern University Medical School in 1933, died May 30, aged 48. He was attending surgeon at Cook County and Passavant Hospitals, and associate professor of surgery at Northwestern University Medical School.

Meyer Backer*, Chicago, who graduated at the University of Illinois College of Medicine in 1936, died June 10 in Fernwood, Mississippi, aged 46.

Richard Birnbaum*, Noble, who graduated at Medizinische Fakultät der Universität, Vienna, Austria, in 1936, died March 29, aged 44. He was formerly associated with the Indian Service.

Stanton S. Boulton*, Towanda, who graduated at Missouri Medical College, St. Louis, in 1899, died October 26, aged 81.

Paul Sterling Carley, Manteno, who graduated at the University of Illinois College of Medicine in 1921, died December 31, aged 56, of coronary thrombosis. He served as psychiatrist at Manteno State Hospital.

Jason D. Chittum*, Sorento, who graduated at Keokuk Medical College, Iowa, in 1891, died March 25, aged 93, of a fractured femur as the result of a fall, bronchopneumonia, and cerebral hemorrhage.

Thomas Cottrell*, Chicago, who graduated at Illinois Medical College in 1906, died May 3, aged 72. He was a member of the staff of Henrotin Hospital until he became ill four years ago.

Raymond E. Davies*, Spring Valley, who graduated at Rush Medical College in 1917, died April 19, aged 66. He was secretary of the Bureau County Medical Society at the time of his death.

George A. Dicus*, Streator, who graduated at Rush Medical College in 1890, died at the home of a son in Taos, New Mexico, June 10, aged 92. He had practiced medicine in Streator for 63 years and was secretary of the North Central Illinois Medical Association for 55 years. In 1954 he was designated "outstanding medical practitioner in Illinois" by the Illinois State Medical Society.

R. C. Fuller, Pittsburg, who graduated at St. Louis College of Physicians and Surgeons in 1898, died in Marion, April 5, aged 83.

Laurence E. Hines*, Chicago, who graduated at Northwestern University Medical School in 1920, died May 13, aged 58. He was professor of medicine at Northwestern University Medical School.

Walter W. King*, Peoria, who graduated at Northwestern University Medical School in 1930, died April 13, aged 53. He was a member of the Clinical Orthopaedic Society and the American Academy of Orthopaedic Surgeons.

Joseph A. Lenz*, Chicago, who graduated at Rush Medical College in 1900, died May 22, aged 80. He had practiced medicine on Chicago's northwest side for 50 years and had been on the staff of the Norwegian American Hospital.

John Estill Miller*, Quincy, who graduated at Baltimore Medical College in 1893, died April 5, aged 83, of bronchogenic carcinoma. He was a member of the courtesy medical staff of Blessing Hospital.

Frederick H. B. Parsons, Chicago, who graduated at Hering Medical College, Chicago, in 1895, died April 22, aged 87, of arteriosclerotic heart disease.

Henry H. Roth*, Murphysboro, who graduated at Illinois Medical College in 1901, died May 19, aged 80.

Alfred A. Schiller, Glen Ellyn, who graduated at the University of Illinois College of Medicine in 1942, died in San Francisco, April 22, aged 39. He was associate professor of physiology at the University of Illinois College of Medicine.

John LeRoy Van Valkenburg, Chicago, who graduated at Long Island College Hospital, Brooklyn, in 1895, died March 30, aged 84.

Joseph Sterling Waldman*, Belleville, who graduated at St. Louis University School of Medicine in 1914, died March 29, aged 69, of mesenteric thrombosis. He was a member of the staff of St. Elizabeth's Hospital.

Emil Weiss*, Arlington Heights, who graduated at the Universita Karlova Fakulta Lékarska, Praha, Austria, in 1919, died June 2, aged 62. He had been at various times, pathologist at the University of Illinois College of Medicine, Northwestern University Medical School and Stritch School of Medicine of Loyola University.

John P. Winn*, Murphysboro, who graduated at the University of Illinois College of Medicine in 1935, died May 21, aged 53.

---

*Member of the Illinois State Medical Society.

‹ ‹ ‹ › › ›

HOUSE OF DELEGATES



The first meeting of the House of Delegates of the Illinois State Medical Society was held in the Hotel Sherman, Chicago, on Tuesday, May 17, 1955.

The meeting was called to order at 9:35 A.M. by the President, Dr. Arkell M. Vaughn, Chicago.

THE PRESIDENT: The first order of business is the report of the Credentials Committee, Dr. Harlan English, Danville, Chairman.

DR. HARLAN ENGLISH, Danville: Mr. President and gentlemen: There are seated 140 delegates and 20 officers and members of the Council. I move you that this number constitute the voting strength of this session. (Motion seconded by Dr. Willis I. Lewis, Herrin, and carried).

THE PRESIDENT: The Secretary has an announcement.

THE SECRETARY: We have with us this morning a gentleman who has been greatly interested in this meeting and cooperative, Mr. Earl R. Benedict of the Hotel Sherman.

MR. BENEDICT: Here we are again fellows, and it is pretty swell. I have seen you several times and every time I tell you we are delighted to see you. I trust when you see me around the Hotel you will stop and say hello. Now, Mr. President, on behalf of the Hotel Sherman I present this gavel to you. Success to you and God bless you.

THE PRESIDENT: Mr. Benedict, we of the Illinois State Medical Society are very appreciative of the courtesies which the Hotel Sherman has always extended to us. I shall always cherish this gavel.

The next order of business is the roll call by the Secretary.

THE SECRETARY: Mr. President, I think the motion of Dr. Harlan English will take precedence and unless asked for, it will not be necessary to call the roll at this time.

DR. EDWIN S. HAMILTON, Kankakee: I so move. (Motion seconded by Dr. Willis I. Lewis, Herrin, and carried).

THE PRESIDENT: The next order of business is the approval of the minutes as published in the July and August, 1954 issues of the Illinois Medical Journal.

DR. CHARLES H. PHIFER, Chicago: I so move. (Motion seconded by Dr. Willis I. Lewis, Herrin, and carried).

THE PRESIDENT: We have a very pleasant duty to perform. It is the presentation of the Outstanding General Practitioner Award. This, as you know, is given every year to the outstanding doctor in Illinois. It gives me great pleasure at this time to introduce Dr. Henry O. Munson of Rushville. I will ask Drs. C. Paul White, Charles P. Blair, and Everett P. Coleman to escort Dr. Munson to the rostrum.

Dr. Munson, it is a privilege and a pleasure to present to you this certificate emblematic of the Illinois State Medical Society's annual award to the General Practitioner for 1955. As a physician for 65 years you typify everything that an outstanding practitioner should be. You are a man whose personal career is beyond reproach. You have kept abreast of medical practice. You have brought credit to the profession by your untiring devotion to the welfare of your patients. In a busy medical career, Dr. Munson, you have found time to participate as a lay leader in your church and in the local government. Whenever called upon for counsel in anything that concerned the well being of your fellowman, you gave it unstintingly. When your country asked for volunteers in World War I you responded. World War II found you too old for active service, but you worked at home, thus releasing younger men for service. The Illinois State Medical Society is proud to present this certificate to you.

DR. H. O. MUNSON: Mr. President, Mr. President-elect, Fellow Delegates, Members of the Council and Dr. Camp, and all others: Words fail me to express my gratitude for this honor that I consider the greatest that my profession could bestow upon me. I do not want to leave out the unknown men on the Committee who selected me. Whoever they may be I do not know. These years have been years of real pleasure to me. I said to someone the other day that I would like to go back and live them over again, even to wade through the mud again. Now, if I may, Dr. Vaughn, venture the next greatest step in medicine, it will be along the line of mental therapists, and we all know how badly we need them. Thank you.

THE PRESIDENT: I would like to introduce the family of Dr. Munson: Mr. and Mrs. Guy Pickenpaugh of Rushville, his daughter and son-in-law; Mrs. R. K. Platt, of Baltimore, a daughter; Mrs. G. J. Smith, Gainesville, Florida, a daughter; Mrs. L. L. Mabee also from Florida, a granddaughter, and last but not least, a great granddaughter, Margaret Mabee.

The next order of business will be the appointment of Reference Committees.

COMMITTEES FOR THE 1955 HOUSE OF DELEGATES

CREDENTIALS

Harlan English, Chairman—Danville; Charles Allison, Kankakee; H. Kenneth Scatliff, Chicago; Patrick H. McNulty, Chicago.

This committee will meet in the entrance way of the Louis XVI Room at 8:00 a. m. on Tuesday morning, May 17, to certify delegates—and prior to each of the other two meetings of the House of Delegates scheduled for 1955.

ATTENDANCE

Lorne Mason, Chairman, Chicago; Joseph F. O'Malley, Chicago; Robert R. Mustell, Chicago; H. K. Moulton, Petersburg; Merrill C. Beecher, Knoxville.
Alternates: Louis Plzak, Chicago; J. K. Rosson, Tamms.

This committee will distribute and collect attendance slips, voting slips, and act as Sergeants at Arms if necessary.

ON REPORTS OF OFFICERS

To receive and report on the reports of (1) the President; (2) the President-Elect; (3) the Secretary-Treasurer.

This committee will meet in the Holiday Room, No. 105, on Wednesday morning, May 18 at 10:00 a. m.

Tom Kirkwood, Chairman, Lawrenceville; G. Henry Mundt, Chicago; Anders J. Weigen, Chicago; Lawrence F. Rockey, Freeport; Darrell H. Trumpe, Springfield.
Alternates: Paul Blackburn, Chicago; C. D. Swickard, Charleston.

ON REPORTS OF COUNCILORS

To receive and report on the reports of (1) the Chairman of the Council; (2) the Councilors of the 11 Councilor Districts, and (3) the Councilor-at-Large.

This committee will meet in the Bull Fight Room, No. 342, third floor) on Wednesday morning, May 18, at 10:00 a. m.

Percy E. Hopkins, Chairman, Chicago; Edward Helfers, Chicago; Allison Burdick, Chicago; William Scanlan, LaSalle; Norman Sheehe, Rockford.
Alternates: L. S. Tichy, Chicago; H. E. Tarpley, Greenville.

ON REPORTS OF STANDING COMMITTEES

To receive and report on the reports of:

1. Committee on Medical Service & Public Relations.
2. Medico-Legal Committee.
3. Committee on Archives.
4. Committee on Medical Education and Hospitals.
5. Committee on Medical Benevolence.
6. Committee on Medical Testimony.
7. Grievance Committee.

This committee will meet in the Life Room, No. 108, on Wednesday morning, May 18, at 10:00 a. m.

William Whiting, Chairman, Dongola; Paul A. Dailey, Carrollton; J. O. Cletcher, Tuscola; H. L. Wallin, Chicago; Wright Adams, Chicago.
Alternates: Bernard Klein, Joliet; Casper Epsteen, Chicago.

ON REPORTS OF COUNCIL COMMITTEES "A"

To receive and report on the reports of:

1. Editorial Board and Journal Committee.
2. Editors of the Illinois Medical Journal.
3. Delegates to the American Medical Association.
4. Advisory Committee to the I. P. A. C.
5. Liaison Committee to Illinois American Legion.
6. Advisory Committee to Veterans Administration.

This committee will meet in the Time Room, No. 110, on Wednesday morning, May 18, at 10:00 a. m.

Warren W. Furey, Chairman, Chicago; Eugene T. McEnery, Chicago; Charles H. Phifer, Chicago; George B. Callahan, Waukegan; E. A. Veach, Vienna.
Alternates: F. M. Nicholson, Chicago; Peter C. Rumor, Effingham.

ON REPORTS OF COUNCIL COMMITTEES "B"

To receive and report on the reports of:

1. Advisory Committee to the United Mine Workers.
2. Advisory Committee to Selective Service.
3. Advisory Committee to Woman's Auxiliary.
4. President of the Woman's Auxiliary.
5. Committee on Blood Banks.
6. Committee on Cancer Control.
7. Committee on Cardiovascular Disease.
8. Constitution and By-Laws.

This committee will meet in the Gold Coast Room, No. 111, on Wednesday morning, May 18, at 10:00 a. m.

L. S. Reavley, Chairman, Sterling; Jean W. Moore, Danville; George E. Kirby, Spring Valley; A. J. Linowiecki, Chicago; E. A. Lukaszewski, Chicago.
Alternates: Nicholas Balsamo, Chicago; James B. Ellis, Belvidere.

ON REPORTS OF COUNCIL COMMITTEES "C"

To receive and report on reports of:

1. Crippled Children's Clinics.
2. Committee on the Coroner's Law.
3. Committee on Diabetes.
4. Educational Committee.
5. Ethical Relations Committee.
6. Fifty Year Club Committee.
7. Interprofessional Relations Committee.

This committee will meet in Room No. 107 on Wednesday morning, May 18, at 10:00 a. m.

Frank H. Fowler, Chairman, Chicago; Carl F. Steinhoff, Chicago; Joseph Sodaro, Forest Park; H. J. Nebel, East St. Louis; N. A. Thompson, Eldorado.
Alternates: Robert Dessent, Chicago; James C. Ellis, DeKalb.

ON REPORTS OF COUNCIL COMMITTEES "D"

To receive and report on the reports of:

1. Committee on Industrial Health.
2. Liaison Committee on Medical Education.
3. Maternal Welfare Committee.
4. Medical Economics Committee.
5. Committee on Medical History.
6. Committee on Mental Health.

This committee will meet in the Holiday Room, No. 105, on Thursday morning, May 19, at 10:00 a. m.

C. Elliott Bell, Chairman, Decatur; John E. Bohan, Alexis; David C. Ryan, Peoria; Andrew Sullivan, Chicago; Walter Bornemeier, Chicago.
Alternates: W. E. Kittler, Rochelle; John C. Wall, Chicago.

ON REPORTS OF COUNCIL COMMITTEES "E"

To receive and report on the reports of:

1. Military Affairs & Emergency Medical Service (Civil Defense).
2. Necrology.
3. Committee on Nutrition.
4. Committee on Nursing.
5. Committee on Physical Medicine & Rehabilitation.
6. Postgraduate Education.

This committee will meet in the Time Room, No. 110, on Thursday morning, May 19, at 10:00 a. m.

John R. Wolff, Chairman, Chicago; James H. Hutton, Chicago; Fred A. Tworoger, Chicago; Russell Jensen, Monmouth; David B. Freeman, Moline.
Alternates: Walter Whitaker, Quincy; Adrien Verbrugghen, Chicago.

ON MISCELLANEOUS BUSINESS

To receive and report on the reports of the following committees, and also on any other business referred by the President.

1. Committee on Rural Medical Service.
2. Committee on Scientific Service.
3. Committee on Tuberculosis Control.
4. Committee on Voluntary Prepayment Plans for Medical & Surgical Care.
* * 5. Committee on Scientific Work.

This committee will meet in the Gold Coast Room, No. 111, on Thursday morning, May 19, at 10:00 o'clock.

Armand J. Mauzey, Chairman, Elmhurst; V. B. Adams, Macomb; Harry Mantz, Alton; Gilbert Towle, Chicago Heights; Caesar Portes, Chicago.
Alternates: Homer Junkin, Paris; S. M. Goldberger, Chicago. (1954: Paul Railey, Jensen, Wright Adams, Karl Vehe)

**The Committee on Scientific Work has no written report. This committee is composed of the Section officers charged with the responsibility of planning the program for the annual meeting. This portion of the reference committee report should contain a general survey of the meeting, suggestions for improvement of the scientific aspects, any changes which might make the 1956 meeting more efficient, a review of the scientific exhibits, etc., the section meetings, and the general assemblies.

THE PRESIDENT: The next order of business will be the consideration of Annual Reports as published in the Handbook, with supplementary reports if desired.

Annual Reports of Officers

PRESIDENT

ARKELL M. VAUGHN, Chicago.

TO THE MEMBERS OF THE HOUSE OF DELEGATES:

The past year has been an arduous but also an interesting and satisfying one indeed.

The satisfaction of knowing that one is working for and with one of the finest groups of men in the world on problems of intense public interest is a great gratification.

First, I must express my thanks to the officers and members of the Illinois State Medical Society for having honored me by permitting me to serve as your 105th president in this, the 115th year of your existence as a society.

The immediate past president, Dr. Willis I. Lewis, and the president-elect, Dr. F. Garm Norbury, have generously given their time to pinch-hit for me when the need has arisen. I shall be eternally grateful to them for their assistance.

As chairman, Dr. Joseph T. O'Neill has masterfully guided the Council during the last year. He has proven a worthy successor to Dr. F. Lee Stone, who likewise displayed outstanding leadership. Dr. O'Neill's genial personality, combined with sound thinking and mature judgment, has resulted in the adjudication of many difficult problems confronting the Society.

Each member of the Council deserves a vote of thanks from the members of the Society for the time, energy, thought and loyalty which they have given to the Society. Increasing complexities of life and of medicine have likewise increased the problems to be considered by the Council. Committee meetings now begin at noon Saturday preceding the council meetings and go far into the night. The Council meeting usually lasts from 9 a. m. until 3 p. m. on Sunday. The attendance is practically 100 per cent.

During the last year, several county or branch society presidents and secretaries have been invited to observe the Council's deliberations. They have left much impressed and informed concerning the activities and functions of the Council. I wish it were possible for each member of the Illinois State Medical Society to attend at least one council meeting. Criticism of the so-called "Ivory Tower," I am sure, would be eliminated. I want to thank the individual members of the Council, one and all, in the name of the Society.

The secretary-treasurer, Dr. Harold M. Camp, gets better with the years, and after 31 years of seasoning, he is really good and mellow. His endurance is amazing, his executive ability astounding, and his judgment excellent. He needs no further eulogy from me. I appreciate his guiding hand and fatherly advice during my tenure of office. I want to thank him and his efficient staff, both in Monmouth and the Chicago offices. Last but not least, orchids to our own Mrs. Frances C. Zimmer for her efficient, loyal and cheerful help to Dr. Camp, the council, myself and the whole society.

The Committee on Medical Service and Public Relations, under the able chairmanship of Dr. Percy E. Hopkins, deserves special attention. The members of his committee have met all challenges this year with competence and courage. Obtaining the services of Walter L. Oblinger as associate counsel to join John W. Neal and as legislative observer was one of the many outstanding achievements of this committee this year. Mr. James C. Leary continued to be indispensable in directing the activities of this committee in his suave diplomatic manner until his death on April 12. Our appreciation goes to him for his hours of hard labor and for his devotion to duty in the cause of the society. We thank him especially for his work with Dr. Limarzi for the Postgraduate Education Committee, and for the valuable assistance he has rendered the last year.

The Postgraduate Education Committee under the chairmanship of Dr. Limarzi with Dr. George Kirby as co-chairman, and with the assistance of Mr. Leary, has done an excellent job.

Dr. Limarzi, chairman of the Scientific Service Committee, with the aid of Miss Ann Fox, has done a creditable job of getting speakers for the local societies.

The Committee on Medical History, under the chairmanship of Dr. James H. Hutton, has succeeded in getting the second volume of "The History of Medical Practice in Illinois," covering the period from 1850 to 1900 published. It will be available by the time of the annual meeting, and we hope that every member of the state society will purchase a copy of this most interesting book. Dr. Hutton is to be congratulated on a hard job well done.

The Woman's Auxiliary has continued in the ladies' loyal manner to promote public health relations. Their help in furthering the sales of "The History of the Practice of Medicine in Illinois" is greatly appreciated. It goes into the record with their work on the benevolence fund, nurse recruitment, subscriptions to "Today's Health" and the public relations program which they have handled so well for years.

The Editorial Board under the chairmanship of Dr. Hutton and the Journal Committee under Dr. Harry M. Hedge have done effective work as is manifested by the improved format and contents of the Illinois Medical Journal. The Journal today is something we can all be proud of among major medical publications.

The Educational Committee under Dr. Charles P. Blair, with the assistance of Miss Fox, has continued to do excellent educational work by way of "Health Talk."

It is not possible to mention here all the two-score committees of the society, but I want to take this opportunity to thank all the chairmen and members for their time and effort in making the Illinois State Medical Society a better one. Without each one of them, nothing could have been effected.

I have travelled from the Atlantic to the Pacific and as far north as Canada attending meetings of the American Medical Association and other professional groups as your representative. I have attended numerous postgraduate and many local society meetings. I have been a guest of the Michigan, Kentucky, Indiana and Wisconsin Medical Societies, and the American Academy of General Practice. I was present at the dedication of the Beaumont Memorial at Mackinac Island, and I attended the Illinois Secretaries' Conference in Springfield in March.

I attended receptions for the famous nurses, Mlle. de Galard, the Angel of Dien Bien Phu, and Mlle. Behut of Belgium, and also that for President Paul Magloire of Haiti. I attended testimonial dinners for Dr. Munson, Dr. Andy Hall, Dr. Anton J. Carlson, Dr. Roland R. Cross and others.

The Illinois State Medical Society exhibit at the State Fair, directed by Dr. Jacob E. Reisch was an outstanding affair.

The past year has been a full but happy one. Now that it is over, I want to point out that with the ever increasing demands made upon the time and energy of your presidents, the task is a gigantic one, unless they have, as I have had, the complete cooperation of every one in the Society.

Respectfully submitted,
ARKELL M. VAUGHN, *President.*

PRESIDENT-ELECT

TO THE MEMBERS OF THE HOUSE OF DELEGATES:

I am deeply appreciative of the honor of being able to write this brief report as President-Elect. If all of you had not been so good to me last year I would not be doing this now. I have neither the outgiving personality nor the energy of President "Kelly" Vaughn. I cannot hope to imitate the "Gulliver's Travels" type of reports he gives at meetings of the Council and probably has summarized for his statement.

Nevertheless I have, thanks to the invitations of kind friends, been able to get around a little. So far I have made all meetings of the Executive Committee and the Council. So far I have inflicted talks on various people at Fifty Year Club celebrations, community gatherings to honor distinguished members, various County Medical Societies. So far I have had free meals given me at Postgraduate Conferences and other gatherings. My digestion and I stand it fine. If your component societies can stand me for another year then all will be well. If there be any constructive activity, other than being a good knife and fork man (or is that destructive?) in which I have been engaged during the past year I think it would relate to closer correlation of organized medicine with the Illinois Department of Public Welfare. I hope this may be continued and extended.

Respectfully submitted,
F. GARM NORBURY, *President-Elect.*

SECRETARY-TREASURER

TO THE MEMBERS OF THE HOUSE OF DELEGATES:

Once more an official fiscal year has ended and an annual report must be prepared for the hand book. This has been another busy year in the Secretary's office, and the entire force has been busy with the many responsibilities assigned. We have been most

fortunate in retaining the well trained but small force of helpers in the office.

If you have occasion to review annual reports from some other state societies, you will note the difference in the number of employees in their respective central offices. One large county society on the west coast recently announced their office personnel as 45. We have four in the Monmouth office, in addition to your Secretary, and the latest addition to the force has been working for six years. In the Chicago office we have three employees regularly in the office working for the Educational Committee, the Business Manager for the Illinois Medical Journal not entirely on a full time basis, and the Associate Editor, who likewise has several other important functions outside of the society duties.

Mr. James C. Leary, who had been working on almost a full time basis for the past 10 years for the society as Director of Public Relations, had two clerical assistants in his office. We were all shocked when the sudden death of Jim Leary was announced on Tuesday evening, April 12. Jim had a coronary occlusion last September, and was hospitalized for a number of weeks in the Evanston Hospital. He remained at home for another month before going to his office for short business sessions every other day.

Jim had been more active in recent weeks, and was ever anxious to carry on any duties assigned to him. He was attending the meeting of the Council of the Chicago Medical Society that Tuesday evening, when he slumped down in his chair, and although the resuscitation squad from a nearby fire department arrived with their equipment in four minutes, they were too late. We will all miss Jim who was known to practically the entire membership of this society, and who was present at many meetings throughout the year.

The 1955 Annual Secretaries' Conference was held at the Leland Hotel, Springfield, on Sunday, March 27. The weather was bad, some snow on the ground and the temperature that morning down to five above zero. Many who had planned to be present were unable to get to the meeting that day. However, there was a registration of 130, coming from all over the state, and an excellent program which had been arranged by the officers of the Secretaries' Conference.

There were five speakers scheduled who are members of our state medical society, two from the American Medical Association, and the president of the Women's Auxiliary to the Illinois State Medical Society, Mrs. Albert T. Kwedar, who made a fine address on the subject, "Auxiliary Aims." Dr. Russell Roth, a guest speaker from Erie, Pennsylvania, gave a most interesting talk on the subject "Putting New Members to Work." Dr. Roth, as a member of the Board of Trustees of his own state society, member of the A.M.A. Committee on Federal Medical Service, and Secretary of his Erie County Medical Society, has a background which aided materially in presenting the subject.

The state society was host at a fine complimentary luncheon, during which a short talk was made by Dr. James H. Hutton on the History of Medical Care in Illinois which will be ready for distribution before our annual meeting. Dr. Arkell M. Vaughn, our president, and Dr. Joseph T. O'Neill, Chairman of the Council, also talked during the luncheon, so that the afternoon program could continue without interruption and the meeting be ended at the scheduled time.

A Nominating Committee appointed earlier brought in its recommendations for the officers of the conference for the next year. These were unanimously elected.

Chairman—William DeHollander, Springfield.

Vice-Chairman—Norris J. Heckel, Chicago.

Secretary—E. N. DuPuy, Quincy.

The group also voted unanimously to ask the Council to authorize the holding of the 1956 Annual Secretaries' Conference in Springfield either the last week in March, or the first week in April. It seemed to be the general opinion of all present that the holding of this important conference each year apart from the Annual Meeting, and as an all day Sunday session should be held in the central part of the state. Springfield being more readily accessible from all parts of the state, seemed to be the most desirable place.

Physicians' Placement Service

The work of our Physicians' Placement Service might well be compared to the commercial placement agencies found everywhere. Physicians registering with our Placement Service correspond to the individuals who register with agencies for employment. One important difference is that we charge no agency fee to either the physician seeking a location, or the community which finally gets the physician desired. We cannot, of course, limit our services to members of the society for most of our applicants are physicians desiring to locate in Illinois after they have finished their internship and have completed their obligation to their country through services with the armed forces.

We always have a number of physicians seeking a location who are graduates of foreign medical schools and have been issued a license to practice in Illinois. When their requests for aid in finding a location are received, we send a questionnaire form to get data concerning their training, whether or not they might be eligible for service, the type of work they desire to do, and also the size of the community they are willing to select for their location.

Likewise we send forms to two or more individuals in the communities desiring a physician so that we may be able to determine whether or not they can properly support a physician in their trade area. We want information concerning the industries in the community, the roads, facilities for a decent home and office for the physician, how near to an acceptable hospital and if the new physician can become a member of its staff. We want to know about the schools, churches, recreational facilities, etc. This information is of great value to physicians seeking locations, and who hope to become part of the community in which they choose to reside and carry on a practice.

We are informed that more than 40 state medical societies now maintain their own Physicians' Placement Service, while the A.M.A. through its Committee on Medical Service acts as a clearing house, sending names of physicians with supporting data concerning them to the individual Placement Services in the state in which the applicant prefers to practice. We frequently receive requests from the Illinois Department of Public Health to send information to physicians who have written the Department regarding Illinois locations. A number of farm papers also automatically send requests from communities wanting physicians, to our office.

Several interesting problems have arisen perhaps more often during the past year, than in previous years which should be of special interest to this House of Delegates.

1. The difficulties resulting from the increasing percentage of alien physicians who solicit our help. There being so few states where alien physicians may receive a license to practice is naturally the reason why we have an increasing number of alien physicians each year seeking our aid to get them properly located.

2. Many communities which had one or more physicians residing there in the "horse and buggy days" believe their community can support a good modern physician. Many of these fail to realize the importance of having a good hospital nearby. We might compare this situation to a lawyer locating in a small town a long distance from the county court house. However, we are becoming convinced more than ever that with good roads, and all physicians using automobiles, many of these smaller communities can have good medical care without a resident physician. One community recently asking for aid in procuring a physician informed

us that they have approximately 800 people in their immediate trade area. It seems quite obvious that this is not nearly enough people to properly support a physician in this second half of the century.

3. Another problem frequently encountered is that pertaining to the alien physician not being eligible for staff membership in the nearby hospitals. Even though he may be acceptable to the community, there is nothing we can do to get hospitals to admit these physicians to staff membership. Hospitals today, almost invariably make county society membership mandatory, as a requirement for staff membership.

4. We have seen several instances recently where a resident physician was compelled to give up his practice to enter the service, and several of them would like to have a replacement for the period he is to remain with the armed forces. This is a problem for many seeking locations for they may work for two years and build up a good practice, then the former practitioner comes home to take over. The community often is too small for two physicians, and the one having had the two years in practice must seek another location.

5. We have a considerable number of physicians on our current list who desire to specialize, and prefer a good sized city for their work. We frequently write to all of our Illinois county society secretaries to determine if they need more specialists, and this list is kept up to date. For example, we have urologists, obstetricians and gynecologists, surgeons of several varieties, and other specialties in which the candidates are interested. Unfortunately it is rare that we have one desiring a location to work as an ophthalmologist, and we could easily place several of them at any time.

6. Although we inform all communities desiring a physician they must have a suitable home and office for the physician, we still find this a problem in a number of towns throughout the State of Illinois.

Many of you have received letters from our office asking for information concerning places in your respective counties where we are informed a physician is needed and can be well supported. To show the increasing importance of this part of our work, I might state that at this time, late in April, 1955, we have a total of 180 physicians listed who desire locations for general practice. Then we have a second list of 120 who desire to locate and practice a specialty.

Mrs. Jane Zimmer Swanson, now in her 14th year in the Secretary's office, spends more than half of her time in the many duties pertaining to the locating of physicians in Illinois. We still have many small towns on the list which have not seemed sufficiently attractive to physicians, to get them to locate there, and it is quite logical to believe that this will continue, although we fail to find any communities in the state where medical care is unavailable.

Council Activities

Your Secretary has attended all meetings of the Council during the past year, and the records will show that he has not missed a single meeting during the past 33 years. The first two of these, during the period in which he was Councilor for the Fourth District before being elected as State Society Secretary in May 1924. Many members of the Society do not realize the many important functions of your Councilors, and it only through attending a meeting of the Council that you can even appreciate the many problems brought before the Council at each of its meetings.

The meetings are not closed sessions, and visiting members of the society are welcome to be present at any of the regular meetings of the Council. During the past year many problems have arisen, and have been acted upon under the direction of the capable Chairman, Joseph T. O'Neill, of Ottawa. It has been a pleasure to your Secretary to work closely during the past year with Dr. O'Neill, and our President, Arkell M. Vaughn. Dr. Vaughn has attended many meetings in all parts of the state, and on several occasions has travelled by plane to get to a meeting some distrance from Chicago.

The Council lost one of its outstanding members on October 7, 1954, when Dr. Joseph S. Lundholm of Rockford died rather suddenly. He had not been well for a number of months prior to that time, but he had been carrying on and like many other prominent members of the medical profession, he died with his boots on. Dr. Lundholm had served his First District over some period of time and had been very active in the affairs of the Council.

Following his death and because the First District covers the top of the state, the Council believed it advisable to appoint a successor for the remainder of the year, and until the 1955 Annual Meeting. Dr. Carl E. Clark of Sycamore was selected to fill this vacancy for the remainder of the fiscal year, and he has been quite active in the duties of this office since that time. This First Councilor District, as most of you know, is composed of all counties bordering on the Wisconsin state line, from JoDaviess on the Mississippi River at the northwest corner of the state to Lake County on Lake Michigan, and the northeast section of Illinois.

The Secretary's Office

As previously stated, we have had the same force of four clerical assistants in our Monmouth office for the past six years, and two of these assistants have been there for 14 and 19 years respectively. Your Secretary was away from the office 140 days last year, spending approximately 100 days in Chicago. He has missed two major postgraduate conferences during the past fiscal year, and then because of conflicting appointments on those days.

Each of these assistants in the office has her own work to do, and during the absence of the Secretary, each of them knows what is expected of her. Frances C. Zimmer, the Secretary's Executive Assistant, is responsible for getting out the Secretary's Newsletter each month. The current mailing list has more than 830 names on it, and the list is increasing each month. Any member of this society desiring to receive this Newsletter regularly, needs only to tell us and another name will be added to the mailing list.

We, therefore, again desire to pay our respects to this fine clerical force, and thank them for their continued good work for the interests of the state society. They are, as you have previously been informed, Frances C. Zimmer, Jane Zimmer Swanson, Wanda Ross and Mary Ward. The entire force attends the Annual Meetings of this Society and are always keeping your best interests in mind in carrying on with their work.

Membership Data

We are pleased to report an increase in membership during the past fiscal year, as you will note by comparing the data with that published in the handbook one year ago. We have had many letters from alien physicians asking if there was some way they could be admitted to membership, as it was a hardship to them to be unable to become members of hospital staffs without membership in the local county societies. We have informed each of them that under the By-Laws of this Society, they cannot be admitted to membership in the county and state societies, and that no exceptions can be made.

Membership as reported for May 1, 1954		9,784
New members during past fiscal year..	463	
Reinstatements	104	
	567	
		10,351

Dropped during the year:	
Died	183
Moved from state	130
Resigned	32
Non-payment of dues	124
Suspended	2
V. A. and Miscellaneous	23
Total dropped	494
Membership, April 30, 1955	9,857

It has been a pleasure for us to work throughout another year with 92 component and cooperative county society secretaries. We have had to send many letters to this fine group, questionnaires, and other data which has been sent at the request of the Council of this Society, the A.M.A., or perhaps a few committees. The responses have been rather generally prompt and satisfactory.

This type of cooperation has been an important factor in our being able to carry on the many projects which were assigned to our office. We desire to thank the many county society officers throughout Illinois for their fine cooperation throughout another fiscal year.

Respectfully submitted,

HAROLD M. CAMP, M. D.,
Secretary-Treasurer.

FINANCIAL REPORT OF THE SECRETARY-TREASURER

RECEIPTS FROM COUNTY SOCIETIES

Fiscal Year Ended April 30, 1955

Adams	$ 4,070.00	Lawrence	820.00
Alexander	585.00	Lee	1,885.00
Bond	.00	Livingston	1,820.00
Boone	715.00	Logan	1,625.00
Bureau	2,275.00	McDonough	2,275.00
Carroll	520.00	McHenry	2,015.00
Cass	780.00	McLean	4,680.00
Champaign	7,702.50	Macon	7,117.50
Chicago Medical Society	364,085.00	Macoupin	1,235.00
Christian	1,397.50	Madison	6,890.00
Clark	455.00	Marion	1,625.00
Clay	585.00	Mason	195.00
Clinton	715.00	Massac	260.00
Coles-Cumberland	2,730.00	Menard	195.00
Crawford	1,170.00	Mercer	455.00
DeKalb	2,405.00	Monroe	390.00
DeWitt	650.00	Montgomery	975.00
Douglas	975.00	Morgan	3,640.00
DuPage	9,750.00	Moultrie	350.00
Edgar	1,040.00	Ogle	2,730.00
Edwards	195.00	Peoria	11,180.00
Effingham	1,170.00	Perry	845.00
Fayette	780.00	Piatt	650.00
Ford	.00	Pike	650.00
Franklin	1,592.50	Pulaski	.00
Fulton	2,145.00	Randolph	975.00
Gallatin	325.00	Richland	.00
Greene	585.00	Rock Island	8,255.00
Hancock	585.00	St. Clair	1,365.00
Hardin	.00	Saline	1,250.00
Henderson	195.00	Sangamon	9,530.00
Henry	1,690.00	Schuyler	325.00
Iroquois	2,860.00	Shelby	715.00
Jackson	3,250.00	Stephenson	2,210.00
Jasper	195.00	Tazewell	2,405.00
Jefferson-Hamilton	2,250.00	Union	975.00
Jersey	780.00	Vermilion	5,395.00
JoDaviess	390.00	Wabash	715.00
Johnson	195.00	Warren	845.00
Kane	10,432.50	Washington	520.00
Kankakee	5,200.00	Wayne	617.50
Knox	3,022.50	White	1,170.00
Lake	9,060.00	Whiteside	2,080.00
LaSalle	5,680.00	Will-Grundy	13,700.00
		Williamson	1,560.00
		Winnebago	10,952.50
		Woodford	585.00

Total	$575,830.00
General Fund	$159,837.50
Benevolence Fund	17,740.00
Educational Fund	177,000.00
A. M. A. Dues	221,252.50
Total	$575,830.00

RECEIPTS AND PAYMENTS

Fiscal Year Ended April 30, 1955

RECEIPTS

Component Societies:		
General Fund	$159,837.50	
Benevolence Fund	17,740.00	
Educational Fund	177,000.00	
American Medical Association Dues	221,252.50	$575,830.00
Subscriptions—Journal		416.15
Advertising—Journal		100,604.37
Exhibits—State Meeting 1954	$ 1,995.00	
Exhibits—State Meeting 1955	7,525.00	9,520.00
Interest on Government Bonds		2,289.00
U. S. Government Bonds Matured		30,000.00
American Medical Association Collection Service		2,305.69
Refund—Blue Cross—Medical Service & Public Relations Committee		439.30
Sale of Industrial Health Pamphlets		240.40
Sale of Medical Histories		459.00
Refunds & Miscellaneous Receipts		19.07
Total Receipts		$722,122.98
Cash Balance May 1, 1954		176,230.78
Total		$898,353.76

PAYMENTS

Secretary's Office Expense		$ 35,325.69
Council Expense		15,270.34
American Medical Association Meetings Expense		9,686.92
State Meeting Expense		21,444.49
Legal and General Counsel Expense		1,000.00
Journal Expense		79,495.59
State Fair Exhibit		953.70
Chicago Medical Society—Services		656.13
Committee Expenses:		
Advisory—I. P. A. C.	$ 65.00	
Advisory—United Mine Workers	287.57	
Archives and Medical History	3,650.46	
Blood Banks	341.66	
Cancer Control	10.00	
Cardiovascular	79.33	
Educational Committee	21,603.36	
Fifty Year Club	325.47	
Grievance	15.63	
Industrial Health	1,398.49	
Interprofessional Relations	508.45	
Investigate Coroner's Office	100.16	
Liaison Committee—American Legion	122.22	

Maternal Welfare	570.14	
Medical Economics	37.06	
Medical Service and Public Relations	33,136.33	
Medico-Legal	46.84	
Mental Health	78.25	
Nutrition	677.87	
Postgraduate	4,561.13	
Rural Medical Service	34.50	
Scientific Service	420.39	
Secretaries' Conference	735.15	
Tuberculosis	109.84	
Woman's Auxiliary	2,299.60	$ 71,214.90
Social Security Taxes		682.81
State Unemployment Insurance		71.61
Federal Unemployment Insurance		86.10
Investments:		
Purchase of U. S. Government Bonds		30,000.00
Refunds of Advances for Postgraduate Surveys:		
United Cerebral Palsy Association	$ 800.00	
Chicago Heart Association	800.00	1,600.00
Advance:		
North Central District Blood Bank Clearing House		6,000.00
Transfers:		
Benevolence Fund	17,740.00	
Educational Fund	177,000.00	
A. M. A. Society Dues	221,252.50	415,992.50
Total Payments		$689,480.78
Cash Balance April 30, 1955		208,872.98
Total		$898,353.76

CERTIFICATE OF AUDIT

FRED N. SETTERDAHL
CERTIFIED PUBLIC ACCOUNTANT
224 Robinson Building
Rock Island, Illinois

TO THE MEMBERS OF THE HOUSE OF DELEGATES:

We have audited the following accounts of your Society for the fiscal year ended April 30, 1955.

Secretary's Office—Dr. H. M. Camp, Secretary.
Journal Office—Mr. L. E. Malley, Manager.
Educational Committee—Miss Ann Fox, Secretary.
Benevolence Fund—Dr. H. M. Camp, Secretary.

Dues received from Component Societies have been verified with duplicate receipts, the master ledger cards of each Component Society, and were compared with the Secretary's report.

The receipts include amounts received for the Benevolence Fund, A. M. A. Dues, and Educational Fund, which have been transferred or remitted to the respective funds.

Journal Advertising receipts have been verified with the records of the Manager who receives and remits same to your Secretary.

Bond interest received was compared with interest due on bonds. Other receipts consist of Exhibit Rentals, Journal Subscriptions, Refunds, etc., which have been taken into account as recorded.

All receipts are recorded by the Secretary and are deposited in the depository bank.

Payments were made by check and were supported by approved vouchers.

The cash balances were reconciled with the statements of the depository banks.

Investments of your Society consist of U. S. Savings Bonds—Series G—with a par value of $60,000.00, Series K—with a par value of $30,000.00 and 31 and 70/100 shares of common stock of the Chicago and Northwestern Railway Company. These shares were issued in lieu of bonds formerly held. These securities, as well as those belonging to the Benevolence Fund, were inspected by us.

As of April 30, 1955, the Benevolence Fund of the Society had cash on deposit of $50,805.97 and U. S. Savings Bonds, Series G, with a par value of $100,000.00 and Series K, with a par value of $40,000.00.

The accounts of the various departments have been well kept and, in our opinion, your Secretary's Financial Report presents the cash transactions for the year.

TheCouncil will be furnished with a detailed audit report, which agrees in totals with your Secretary's Report.

Respectfully submitted,
FRED N. SETTERDAHL,
Certified Public Accountant.

CHAIRMAN OF THE COUNCIL

TO THE MEMBERS OF THE HOUSE OF DELEGATES:

The work of your Council has been both voluminous and varied during the past year. Much of it has dealt with matters of policy that are of particular interest to each of us as physicians in private practice.

Since the selection of your Chairman, following the last meeting of the House of Delegates in May 1954, the Council has met in June, August, October, December, January, March and April. A special meeting was held, March 27, 1955, during the Annual Secretaries' Conference in Springfield, to consider a resolution relative to the handling of the polio inoculations. The regular meetings of the Council have all been held at the Hotel Sherman in Chicago. The sessions convened at 9 in the morning. Most lasted until 3 p. m. with an interruption for luncheon at 12:30. A tremendous amount of business was transacted at each of these sessions which, to obviate repetition, will not be reviewed in this report because of the comprehensive presentations by Councilors and Committee Chairmen.

The attendance of the Councilors has been excellent with few meetings being missed by the majority of members. Some Councilors were absent for one meeting, but only because of an absolute inability to attend. All the Councilors, as individuals, are hard-working practicing physicians. Because of this, they deserve the thanks of the House in general for their sincere and honest efforts to carry on the business of organized medicine in Illinois.

The Council has functioned smoothly and efficiently in the opinion of this Chairman. Because of the volume and complexity of the business to be considered, much of the work is assigned to some particular Committee which, in turn, after thoroughly investigating the subject matter, reported back to the Council with recommendations for action. These Council appointed Committees have functioned conscientiously and efficiently during the year. I wish to commend the Chairman and individual members of these Committees for their excellent performance in fulfilling their responsibilities.

Dr. Harold M. Camp, Secretary of the Illinois State Medical Society, is also Secretary of the Council. The amount of work accomplished by Dr. Camp and his assistants is tremendous. He prepares the agenda for all matters that are to be considered by the Council which is included in a letter that reaches the Councilors approximately one week before each Council session. Your Chairman wishes to express his sincere appreciation to Dr. Camp and his assistants for their help during the past year. Dr. Camp's intimate knowledge of the Society and his wise guidance have been most valuable.

During the year the Council was saddened by the sudden death of Dr. Joseph Lundholm of Rockford, Councilor of the First District. Dr. Lundholm had endeared himself to all members of the Council. Because his death occurred early in the Council year, it was decided to appoint a successor for the remainder of the year only. Because the First District represented a large number of county medical societies, the Council believed these physicians should be suitably represented for the rest of the year. Dr. Carl Clark, Sycamore, was appointed to fill the vacancy until the May 1955 meeting of the House of Delegates. This, the Council believed, would give the delegates from the First District an opportunity to recommend a Councilor to complete the term of Dr. Lundholm which does not expire until May 1956.

In July 1954, the Council appointed Mr. Walter Oblinger, Springfield, legislative representative of the State Medical Society. This appointment stemmed from the recommendation of the Committee on Medical Service and Public Relations with which the Council heartily concurred. Mr. John Neal was named General Counsel of the Society at the same time.

One of the highlights of the year was the testimonial dinner for Dr. Roland R. Cross, Director of the Illinois Department of Public Health. The affair was held at the Leland Hotel in Springfield, Tuesday evening, February 8. Two citations were presented by the State Medical Society: One to Dr. Cross personally, and the other to the Health Department. Baxter K. Richardson, Ph. D., Deputy Director of the department, accepted the citation for the department. This tribute was arranged because of the close association of Dr. Cross and his department with the Illinois State Medical Society. For many years Dr. Cross has worked unstintingly to improve the health standards of the people of Illinois. In a true spirit of cooperation toward this goal, Dr. Cross has presented his policies for discussion by the Council of the State Medical Socety before they were put into working effect. Your Council believed that such a close association and working relationship with the members of the medical profession should be given some public acknowledgement. The dinner was well attended by the Councilors and other officers of the State Medical Society, by many members of the Legislature and by members of the Governor's Cabinet of which Dr. Cross is a member. Insofar as your Chairman knows, this event marked the first time such public recognition by a State Medical Society has been accorded to a state department of health.. This public tribute extended by the Society has created numerous favorable comments from members of the medical professsion in other states. Your Chairman feels that this was a memorable occasion. This was not only a public relations gesture of the highest character, but a sincere recognition of a person who, over the years, has made a deep impression on each of the Councilors and, particularly, your Chairman. No eulogy by me could describe adequately the respect and affection with which Dr. Cross is held by the Council and by the profession generally in Illinois. To say it aptly: It could not have happened to a nicer fellow.

The imminent report on the Salk vaccine for poliomyelitis was considered extensively by the Council in recent months. In March we were fortunate in hearing several leading figures in the public health field in Illinois discuss the forthcoming evaluations of the Francis report. Since every physician in Illinois would be vitally concerned with the results, your Chairman suggested that this portion of the Council session be open to free discussion. The outcome was the adoption of a resolution, which previously had been adopted by the Council of the Chicago Medical Society. The resolution, suggesting that the physicians in Illinois would like to administer the vaccine in their offices for the first and second grade students instead of the mass inoculations, was forwarded to the National Foundation for Infantile Paralysis. This subject was further discussed at the special Council meeting in Springfield on March 27. The entire treatment of this project was discussed frankly by your Chairman with the representatives of the County Medical Societies who attended the Secretaries' Conference. This matter is touched on lightly in this report, because your Chairman believes that it will be presented in comprehensive detail by other Committees reporting to the House of Delegates. In no way does your Chairman wish to usurp their prerogatives.

Another major activity of the Council was the development of a plan to consolidate the offices of the Educational Committee and that of the Public Relations Counsel. This plan was instigated by a motion presented by Dr. Arkell M. Vaughn, President of the Society. A committee was appointed, consisting of Drs. Charles P. Blair, Monmouth; Arthur Goodyear, Decatur; and Edward Piszczek, Chicago. This committee has worked long and diligently, frequently consulting with officers of the Society. No definite decision has been made as this report is being prepared. However, one undoubtedly will have been reached so that the House of Delegates can be informed.

The Council was asked to consider the underwriting of a plan to develop a regional clearing house for blood banks. This project, which was presented by Dr. Coye Mason, was favorably acted upon by the Council. Your Chairman merely wishes to call this plan to the attention of the House of Delegates, since the project will be explained in full in the report of the Blood Bank Committee of which Dr. Mason is Chairman.

It is with a heavy heart that the Chairman officially informs the House of Delegates of the sudden death of Mr. James C. Leary, Public Relations Counsel of the State Society. "Jim" went out in action, as he would have liked, while working during a Council meeting of the Chicago Medical Society, the evening of April 12. The Committee on Medical Service and Public Relations will, I am sure, make a full report of Jim's unfortunate death. Your Chairman, however, wishes to acknowledge his sincere appreciation for the helpful advice and cogent counseling given by Jim. We, in the Council, shall miss him and I know I express the opinion of all my fellow Councilors when I say he will be hard to replace. Jim had the esteem, affection and admiration of the entire Council. He realized our frailties in the matters of public interest and loved and respected us in spite of them. In the manner of his passing on, I am sure he would feel like Alfred Tennyson's "Sunset and evening star, and one clear call for me—And may there be no moaning of the bar when I put out to sea."

Your Chairman has had the firm belief that every Council Committee should act as a unit rather than react to the opinions and decisions of its Chairman. With that thought in mind the Chairman has written to the head of each Committee and urged him to have at least one meeting of a committee during the year. Many of these Committees, while entirely justified, have very little business to transact in some years.

The Committee on Medical Service and Public Relations and the Educational Committee have by far the largest number of activities which will be apparent when you have read their respective reports. Your Chairman has attended most of the meetings of these two Committees. These two special Committees have functioned well this past year and are entitled, in my opinion, to appropriate laudatory comments for the amount of work they have accomplished and the efficiency with which they did it.

Your Chairman is particularly interested in the work of the Educational Committee on Television. As the Chairman sees it, this Committee is charged specifically

with the dissemination of information on health to the lay public of Illinois. With the growing improvement of television reception throughout the state, it appears to your Chairman that every effort should be made to return our television program to the air, even though to do so we should have to obtain commercial sponsorship.

In October 1948 your Educational Committee launched the Illinois State Medical Society as the first State Medical Society to engage television in health education. In December of the same year, through the Educational Committee, we became the first State Medical Society to present weekly "live" programs on WGN-TV which we continued for five and one-half years, winning an award at the conclusion of our first year based on popular vote by lay viewers. During the entire period our "How's Your Health" received considerable favorable press publicity.

This was accomplished without a sponsor through the goodwill cooperation of WGN-TV and the enthusiastic cooperation and sincerety of participating physicians. Many state medical societies have not only imitated our pioneer efforts, but enlisted our assistance in developing programs based on our own invaluable experiences. The Educational Committee of the Illinois State Medical Society deserve special commendation for these pioneer efforts in utilizing television as a teaching medium. I strongly urge the House of Delegates to instruct the Educational Committee to make every possible effort to return to the field of television. I feel sure that this subject will be brought to you by this Committee's Chairman, Dr Blair.

The Advisory Committee to the Illinois Public Aid Commission has held numerous meetings, most of which it was your Chairman's privilege to attend. Special praise must go to this Committee which has worked so strenuously under the brilliant Chairmanship of Dr. Montgomery.

The Scientific Service and Postgraduate Education Committees have both fulfilled their obligations under the chairmanship of Dr. Louis R. Limarzi. Both have served the medical profession of the state with programs for their regular county medical society meetings and conferences offering postgraduate medical education.

The Illinois Medical Journal has improved vastly. Credit should go to the Editors, Dr. Camp and Dr. Van Dellen, and the Journal and Editorial Committees. Mr. L. E. Malley, Business Manager, must be complimented for his enterprising interest in our official publication.

Your Chairman wishes to thank the members of the Finance Committee for their ardous activities in handling the financial affairs of the Society. Their zeal and business acumen are particularly commendable.

Your Chairman should like to direct your attention to the great amount of work done by many individuals, particularly Mrs. Frances Zimmer as the Executive Assistant to the Secretary, Dr. Camp. She has attended all Council meetings, has shouldered the responsibility for the accuracy of the Minutes, has furnished me with a digest of all Council actions and has been of inestimable assistance in numerous ways. I cannot thank Mrs. Zimmer enough for her many kindnesses. Mr. John Neal, as legal adviser, has helped us immeasurably. Mr. James Leary, as Public Relations Counsel, was always of invaluable aid. Mr. Walter Oblinger, the new Legislative Representative, has rendered a valuable service, particularly with his timely, informative letter on legislative activities. Miss Ann Fox, Secretary of the Educational Committee and producer of our pioneer television presentations, deserves a special word of commendation for her assistance during the year. I should also like to call attention to the two assistants in Jim Leary's office, Clara Mai Rutherford and Ardyth Cobb; both have done excellent work, especially for the Postgraduate Education Committee and the legislative letter prepared by Mr. Oblinger.

Once more let me acknowledge my appreciation to Dr. Camp whose vast experience and kindly understanding have eased the work of your Chairman.

This report is submitted as a summary only of the multitudinous activities of your Council. The year as Chairman has been a pleasant one. To be chosen for this position by my fellow members is a personal joy. I wish to offer a personal "thank you" to each individual Councilor and the Chairmen and members of each of the Council Committees for their friendly cooperation and to the House of Delegates for its trust and confidence.

Respectfully submitted,

JOSEPH T. O'NEILL, M. D., *Chairman of the Council.*

DR. JOSEPH T. O'NEILL: I have a supplementary report.

This morning the Council considered a resolution which they should like to introduce before the House of Delegates for your action at this time. Since the Committee on Medical Service and Public Relations is vitally interested in this resolution I will ask Dr. Percy E. Hopkins if he will read the resolution and answer any questions that may be asked.

DR. PERCY E. HOPKINS, Chicago: This resolution is presented because of the fact that it has been introduced into the State Legislature hearing today having to do with the proposed amendment to the Medical Service Plan Act which would provide as benefits dental service. It is questionable whether there is in existence an insurance contract being sold in the state that provides dental service. Second, when this was first proposed by the dental people it was with the idea in mind that so-called oral surgeons were being discriminated against — the small group of M.D.'s who are especially trained in the particular field of oral surgery. You will recall there is still considerable controversy as to the definition of oral surgery, that was put forth by the Special Committee of the American Medical Association and as put forth by the Board of Trustees and by the American Dental Association, such report having been made in Miami last December and then sent back to the Trustees for further consideration. In the May 7 issue of the Journal of the A.M.A. there is a report which will come up for consideration at the meeting in Atlantic City. This matter is still controversial. The Committee of the A.M.A., for the present at least, decided to accept the definition of oral surgery as presented by the Dental Association. In that definition they put as the reason for accepting it the statement that the Board of Trustees after careful search of the Proceedings of the House of Delegates over a period of years is unable to find any situation in which a definition of some of the ancillary services of medicine, such as osteopathy and others, have been defined by the A.M.A. It is a question now what the House of Delegates is going to do with that report. The demand for urgency comes from the fact that an amendment to the Blue Shield will have to do with dental services beyond the ordinary extent that is contemplated by the resolution. That is the background, the resolution will explain itself.

Whereas, House Bill No. 950 recently introduced into the Illinois General Assembly proposes to amend various sections of The Medical Service Plan Act, enabling legislation enacted in 1945 at the request of the Illinois State Medical Society, which proposed amendments would make it possible for general dental services to be included in the contracts written by medical service plan groups; and

Whereas, much valuable practical and actuarial experience has been developed as to the insuring of medical and surgical expenses through Blue Shield

Plans during the past ten years, and substantial reserves from such operations have been accumulated for the protection of the subscribers to such plans; and

Whereas, the opening of such plans for the inclusion of general dental services without adequate study of the problem might well result in the depletion of such reserves, and might adversely affect the financial stability and growth of medical service plans now in operation; and

Whereas, the Illinois State Medical Society looks with favor upon the broadest possible coverage under voluntary insurance plans, and feels that the dental profession should be assisted and encouraged in developing their own voluntary prepayment insurance plans covering dental expense, but does not feel that existing medical and surgical plans should be disrupted or disturbed by the sudden inclusion of service of this type; and

Whereas, the question of the proper definitions and relationships between dental service and oral surgery is under active consideration by representatives of the American Medical Association and the American Dental Association, it being highly desirable that such questions of policy be determined at the national level by the two professions,

Now, therefore, for the above reasons, the House of Delegates of the Illinois State Medical Society hereby records its disapproval of House Bill No. 950, and requests that the problems and questions which it embraces be studied by representatives of the Illinois State Medical Society and the Illinois Dental Society before legislative action is taken, and

Be it further resolved, that copies of this resolution be forwarded to the appropriate members of the Illinois General Assembly and to the officers of the Illinois Dental Society.

THE PRESIDENT: What action do you wish to take on this resolution? The Chair recognizes Dr. Frank Fowler of Chicago.

DR. FRANK FOWLER, Chicago: Mr. Chairman and Members of the House: I move that we suspend the order of business of this assembly and consider this resolution presented by Dr. Hopkins immediately. (Motion seconded by Dr. Harry Mantz, Alton, and carried).

THE PRESIDENT: Without reference to a Reference Committee?

DR. FOWLER: Yes. I move that the House of Delegates accept the resolution. (Motion seconded by Dr. Mather Pfeiffenberger, Alton, and carried).

Reports of Councilors

FIRST DISTRICT

To the Members of the House of Delegates:

It is with considerable humility that I approach this new task as Councilor for the First District. The late Dr. J. Lundholm filled the post so ably for many years and needless to say he will be greatly missed by his many friends of the First District. He not only was a valued Councilor but was held in high personal esteem by all of the physicians who came to know him so well.

It takes many months to learn all of the Counties and their problems. I shall strive to do this and carry on as well as my predecessor. Specifically, in this short time, I have only been able to meet with a few units. A Roster of new officers and meeting times and places has been compiled which will enable me to carry on in an orderly manner. Those Societies upon which I have called have been very cooperative in promoting all of the functions of organized medicine. One Society, with major organization problems, has been helped toward a solution of their problems. The presentation of several 50 year medals to venerable members has been a distinct and pleasant privilege.

The time, though short, has been pleasant and many more things can be accomplished as time and experience will allow.

Respectfully submitted,

Carl E. Clark, M. D., *Councilor, First District.*

SECOND DISTRICT

To the Members of the House of Delegates:

The Councilor of the Second District has had a most enjoyable year. Each County Society has been visited and no problems have been presented to the Councilor from any of the component societies.

During the year four 50-year certificates have been presented in the Councilor District. The presentation of such certificates has been one of the most gratifying duties to your Councilor. It is always a pleasure to welcome those physicians who have devoted so many years of their lives to medicine into the exclusive membership.

During the year the Sterling Community Hospital was the recipient of a community bond issue which will furnish a number of new beds and it will bring the total expenditure of this hospital up to two million dollars over the last three years. Congratulations to this community for their zeal in providing adequate medical care for the people of their communities.

The Councilor feels extremely grateful to the officers and members of the component societies for the extreme courtesy which has been extended to him during the year and for the cordial welcome he has always had at the meetings of these societies. It has been a real pleasure to have served as Councilor for the Second District.

Respectfully submitted,

Jos. T. O'Neill, *Councilor, Second District.*

THIRD DISTRICT

To the Members of the House of Delegates:

As it should be with all active and large county societies, the Chicago Medical has advanced the purposes and functions of a county society. New activities have been included and the programs of the past have been strengthened.

This Society is composed of 15 branch groups and is affiliated with 23 specialty groups. Every effort has been made to bring the best in medical science to its membership.

DOCTORS EMERGENCY SERVICE

The Doctors Emergency Service in 1954 took care of 4,309 emergency calls, which is double the number of patients seen in 1953 and bringing the total, since the service was inaugurated in 1951, to 9,800 cases handled.

The participating physicians on this panel are doing a wonderful job not only in saving lives but in the promotion of good first line public relations with the public.

GRIEVANCE COMMITTEE

The Grievance Committee of the Chicago Medical Society handled 198 complaints in the past year. About four doctors were called in and eight complainants and the cases were settled satisfactorily. A few cases required additional investigation. Most of the complaints were due to misunderstanding and were settled without the necessity of calling in the doctor and complainant. In some cases the Committee recommended an adjustment in fees and a friendly settlement was reached. Four doctors were referred to the Committee to Investigate and Consider Informal Charges of Unethical Conduct. A very small proportion of the number of complaints received represents justifiable grievances against physicians.

EMERGENCY MEDICAL SERVICE

There has been no appreciable change in the implementation of the health services program in Chicago during the past year. However, the event of the hydrogen bomb has increased the interest and concern in civil defense problems especially in the health services field.

The Illinois Civil Defense Agency in December, 1954 distributed a hydrogen bomb Fact Sheet which provides a sound base for civil defense planning in this field.

With the release of more information regarding the hydrogen bomb, planning the problem of pre-attack dispersal of populations in metropolitan areas is beginning to receive major attention and some sound planning is beginning to evolve.

Paralleling the planned dispersal, the problem of mutual aid activity in counties and cities surrounding metropolitan target areas is receiving greater attention. The volume of the dispersal problem is such that the counties and cities which may be involved in caring for a large volume of displaced persons should reconsider their mutual aid plans and become prepared for much greater activity in this respect than previously anticipated.

The problem exerting the greatest impact in the civil defense field this year is the one of radioactive "fallout." This became evident as a major problem following the hydrogen bomb test in the Pacific ocean in March, 1954. This brought into proper focus a problem which can effect each county within the state, creating an area of great danger to the health of the population in areas as large as forty miles wide and 150 miles in length. Plans are under way to provide proper radiological monitoring in these areas as they develop and to thus provide information throughout the state which can save many lives.

The Chicago Civil Defense Corps has recently taken action to begin the implementation of the Chicago portion of the basic state plan for the utilization of improvised hospitals and first aid stations. Appreciable progress in this development should soon be evident. The Council of the Chicago Medical Society, at its April, 1955 meeting recommended that the Chicago Civil Defense Corps employ a full time medical director and staff to implement the activation and development of its health services program.

A civil defense immunization program of statewide volume was initiated by the issuance of a proclamation by Governor Stratton in March, 1955 declaring the month of April, 1955 as "Civil Defense Immunization Month" for all voluntary civil defense workers against smallpox, typhoid fever and tetanus. Preliminary information would indicate that this program has widespread interest and that, in addition to providing immunization for civil defense workers, it can be of assistance to the over all Illinois immunization program as advised by the State Board of Health.

Your Committee has assisted in the development of the above items and will continue to initiate or assist further developments in the health services aspect of civil defense in Chicago.

COMMITTEE TO INVESTIGATE AND CONSIDER INFORMAL CHARGES OF UNETHICAL CONDUCT

The Committee has been very active through the year considering all cases which have come before it and referring considerable work to the Ethical Relations Committee. During the year eight monthly meetings were held.

Eight cases were called in before the Committee and in four of these cases recommendations were made to the Council that charges of unethical conduct be preferred.

ETHICAL RELATIONS COMMITTEE

The Ethical Relations Committee has been active and has met problems as they were presented. We deeply regret the recent death of the Chairman, Dr. Arthur C. Taylor, and will keenly feel this loss.

COMMITTEE ON ADOPTION LAWS

A Committee of the Chicago Medical Society is studying the adoption problems as they relate to the City of Chicago.

CLINICAL CONFERENCE COMMITTEE

The Chicago Medical Society Annual Clinical Conference was held March 1, 2, 3 and 4 at the Palmer House. Registration for this event ran well ahead of the past few years and everyone who attended seemed to feel that this was an excellent meeting.

Lectures, demonstrations and Color Television made a well balanced program. The Scientific Exhibits were excellent and were well attended. This Conference requires no small amount of hard work by quite a few people, but it is a rewarding effort of which the Society is proud.

PRESS RELATIONS

The Press Relations Committee is frequently called upon to give advice in connection with the proposed appearance of members of the society on television, radio or before public assemblies and in many instances has simply called to the attention of the individual doctor that much valuable and educational information can be presented without any suggestion of advertising or publicity on the part of the individual involved. The Committee is cognizant of the fact that if accurate health information is to be given to the public, the source of such information must be members of the medical profession. No instances of transgression in connection with such a procedure have been called to the attention of the Chicago Medical Society.

TUBERCULOSIS CONTROL COMMITTEE

The Tuberculosis Control Committee of the Chicago Medical Society is one of the most active committees of the Council and meets periodically preceding the monthly Council meetings.

This is the tenth year of the Tuberculosis Control Committee and its actions and work have done much to bring about the favorable tuberculosis situation in which the Chicago area finds itself today.

The following achievements took place during the year:

1. Dr. Ernest E. Irons was re-appointed to the Board of Directors of the Municipal Tuberculosis Sanitarium for a three-year term. Dr. Irons on April 1, 1955, received the Good Government Award for 1955 from the Junior Association of Commerce and Industry at a banquet in the Crystal Room of the Palmer House.

2. The Municipal Tuberculosis Sanitarium achieved one of its life-long ambitions during the year. Early in 1954 there was no female waiting list, towards the end of 1954 a waiting list no longer existed for the sanitarium.

During the year 1954, 4,250 new cases of tuberculosis were reported in Chicago and 558 deaths from tuberculosis occurred within Chicago.

All of the available beds at the Municipal Tuberculosis Sanitarium, Bryn Mawr Avenue and Pulaski Road, were occupied. The North Riverside branch continued to be full and about 100 children continued to be hospitalized at the Municipal Contagious Disease Hospital.

With the elimination of the waiting list pre-sanitarium therapy at the clinics has been greatly increased.

The incidence of tuberculosis still remains high in Chicago. The deaths from tuberculosis have been greatly reduced.

At the present time two-thirds of the tuberculosis problem is in the male sex.

3. The Suburban Cook County Tuberculosis Sanitarium District opened its new Hospital-Sanitarium to patients on February 14, 1955. Formal dedication of the institution took place on Sunday, March 6. Dr. Frank Fowler, President of the Chicago Medical Society, spoke for the Society.

In the suburbs, with almost one million population, 323 new cases of tuberculosis and 61 deaths were reported during the year 1954.

4. The Chicago State Tuberculosis Sanitarium, in the Medical Center, continued to increase its population and at the present time has been maintaining an average of 250 patients.

5. The case finding program instituted by the Municipal Tuberculosis Sanitarium in the Bridewell in April of 1954 was in full operation and about 5% of all inmates of the Bridewell were found to have either active tuberculosis or residual signs of chronic tuberculosis. This screening program has been very profitable and the city has provided extra hospital facilities for these victims of tuberculosis in the new Bridewell hospital addition.

6. During the past two years the Tuberculosis Control Committee has recommended to the Cook County Board of Commissioners that all inmates of the Cook County Jail be screened for tuberculosis on admission and discharge. This program has not been put into effect and the Cook County Jail remains the only institution of its size in the country where this operation is not carried on in its medical program. At the present time a concentration of effort to achieve this is being carried on by the Committee.

7. The mobile unit surveys conducted jointly by the Municipal Tuberculosis Sanitarium, the Suburban Cook County Tuberculosis Sanitarium District, and the Tuberculosis Institute of Chicago and Cook County during the year 1954 took a total of 822,203 films. The Tuberculosis Control Committee is gratified by this 30% increase in the number of small films taken over the year 1953. The medical profession lends its entire support to this X-ray survey program.

8. More and more hospitals are requiring chest X-rays on all admissions. At the present time approximately one-third of all the patients entering hospitals are having admission X-rays. The Committee hopes that this will be a requirement for admission to all hospitals in the area.

9. A subcommittee of the Tuberculosis Control Committee has been studying the problem of making every doctor's office a tuberculosis detection center. Already many of the hospitals require that staff physicians have a yearly chest X-ray on record. This has stimulated the general annual X-ray program of all hospital employees as well as annual general surveys in the hospital area.

10. The Committee has approved two new legislative measures. The first to increase the membership of the Municipal Tuberculosis Sanitarium Board from three to five members. The second to continue the peggedlevy of the sanitarium at $5½ million a year.

CHILD HEALTH

The main concern of the Child Health Program continues to be the Chicago School Health Program.

The budget of the Bureau of Health Services has again been increased. It now approaches the half million dollar mark. The vision and hearing screening program is paying large dividends in a steady decrease in the number of school children handicapped in their learning by poor function in sight and hearing. With the steadily increasing number of teacher nurses, the school health councils are now over 50 in number. In each one, a member of the Chicago Medical Society plays a leading role in solving the health problems of each school in the program. The health situation has probably never been as favorable to Chicago school children as it is today and the Chicago Medical Society has never before been as active in the maintenance and improvement of public school health standards.

COMMITTEE ON HEALTH AND ACCIDENT INSURANCE

The Group Health and Accident Insurance program of the Chicago Medical Society has completed one year as of November 30, 1954. The total claims accepted by the carriers equaled 242 and all but 29 had been completed by November 30, 1954. These 29 were still receiving benefits. The plan is operating satisfactorily from the viewpoint of the physicians and also for the carrier.

The new members who have come into the Society within the last year have been given the opportunity of enrolling in the program also. They are permitted to enroll without examination. Those in the category of impaired risk may be given plan B or C. Those members who were in the Society at the time of the original enrollment but did not apply were given the opportunity to enroll in the plan—but must submit to an examination.

COMMITTEE ON INSURANCE

The Council of the Chicago Medical Society authorized the chairman of the Council to appoint a "Committee on Insurance." This committee was given three specific chores. One was the study of a short satisfactory form for medical reports to insurance companies and like organizations. Second was the investigation of some type of life insurance (probably term) for younger members of the Society. Third was to study, investigate and recommend on the problems pertinent to medical liability insurance. This committee has been appointed and has been active in all of its projects.

BLUE SHIELD AND BLUE CROSS

The Blue Shield Plan of Illinois Medical Service with headquarters in Chicago paid a total of $7,462,589 to physicians for the care of 140,804 members during the year 1954. This marked a new record high in payments to physicians in any year by this Blue Shield Plan and brought total benefits paid by this Plan to physicians on behalf of members to $23,165,301.

Another important feature of 1954 activities was the increase in benefits effective August 15. This included increased allowances for a number of operations and the addition of office surgery, listing 16 specific operations so covered.

At the same time, in-hospital medical care allowances were increased substantially, and the following allowances are now provided for professional medical (nonsurgical) care of members hospitalized for more than two consecutive days, retroactive to the first day, limited to one visit per day and to one physician: $5.00 for each of the first 5 hospital visits, and $3.00 for each of the next 65 daily hospital visits. Maximum benefit 70 hospital visits which may be repeated when a member enters any hopital within 90 days of discharge from any hospital.

Many anesthesia allowances were increased and the maximum raised from $25.00 to $35.00. And the maximum radiology and pathology benefit was made available in a 90 day period instead of per calendar year.

Enrollment of the millionth member in Blue Shield during 1954 was another goal achieved by this Blue Shield Plan during 1954 and membership in this Plan at the end of the year stood at 1,084,573 members. This Plan operates in 97 counties in Illinois.

While the Blue Shield Plan of Illinois Medical Service is a plan developed by doctors to help their patients meet their doctor bills and is operated by a statewide Board of Trustees made up entirely of physicians, nevertheless, it is offered as a companion to the Blue Cross Plan of Hospital Service Corporation.

Last year this Blue Cross Plan provided hospital care benefits totaling $38,090,523 for 315,827 patients....the highest figure in its 18 year history. This Blue Cross Plan, the fourth largest Blue Cross Plan in the country, now has a membership of 2,120,443 members. While Blue Shield is 11 years younger than Blue Cross it is

growing at an even more rapid rate than Blue Cross did in its early years. Nationally Blue Cross now has over 47 million members and Blue Shield over 31 million.

The first non-group (individual) enrollment for Blue Shield and Blue Cross was made available in Decatur in 1954. It is planned to make this offering available in other sections of the state in 1955 as soon as circumstances permit.

The annual reports just issued by these two Plans show both in a sound financial position, with adequate reserves....and both plans look forward to 1955 as a year of continued growth and service to members, physicians and the communities they serve.

POSTGRADUATE COURSES

New attendance records were established for the two postgraduate courses held annually by the Society. Physicians from all parts of the country registered for the courses held at the Sheraton Hotel during the weeks of November 8 to 12 and November 15 to 19, 1954. The first course given was "Basic Principles and Recent Developments in Internal Medicine" and the second course was "Basic Principles and Recent Developments in General Surgery."

The Postgraduate courses, started in 1947, were designed to bring the latest advances in medicine and surgery to the physician. The Committee has always endeavored to obtain outstanding authorities as lecturers for the programs. The courses are open to all physicians in good standing of their county medical societies.

Abstracts of all papers in book form were given to all those attending. These have proved to be very helpful and so much in demand that similar books will be distributed to those registering for the 1955 courses.

Two postgraduate courses will be held in the fall of 1955. A course in "Basic Principles and Recent Developments in Pediatrics" will be given during the week of October 17-21 and a course in "Basic Principles and Recent Developments in Obstetrics and Gynecology" will be given the week of October 24-28 at the Knickerbocker Hotel. It is hoped that a large number of physicians from Cook County and the rest of the State will avail themselves of the opportunity to attend the 1955 postgraduate courses.

PUBLIC RELATIONS COMMITTEE

The Third Councilor District, containing as it does, the second largest county medical society in the country, poses some unusual problems not found in the usual county society. The volume of work and study involved in some of our society activities—those which the American Medical Association classifies as public relations activities—is undertaken by separate committees. This division of labor is necessary because of the size of our physician population with its resultant volume of work required in the different fields.

Our Public Relations activities might be considered under nine topics: Health forums; Mediation committees; Emergency call plans; Press relations; Speakers bureau; Public service projects; Citizenship projects; Indoctrinating members; Medical care of the indigent.

Work continues along these lines and we solicit your cooperation and suggestions to insure its success.

WOMAN'S AUXILIARY ACTIVITIES

The achievements of the Woman's Auxiliary to the Chicago Medical Society and its thirteen Branch Auxiliaries were many during the year 1954-55. Membership and organization were stressed. Approximately 3,000 women were contacted and asked to join the Auxiliary. The membership was increased by 145, making a total of 962 Auxiliary members in Cook County. An Auxiliary to the Southern Cook County Branch of the Chicago Medical Society was organized on October 7, 1954, with a membership of 40. An Auxiliary to the Douglas Park Branch of the Chicago Medical Society was organized on February 21, 1955 with a membership of 12.

The programs throughout Cook County were varied and on such subjects as: The Nurse and Bedside Nursing, Camps for the Diabetic Child, the American Medical Education Fund of the American Medical Association, Mental Health, Medical Legislation, talks on Medical History, Films on Polio, Nursing, Cancer and Tuberculosis. In November, a Public Relations Day Luncheon and Program was held with Dr. Walter C. Alvarez as the guest speaker. There were 419 present with 137 civic leaders as guests of the County Auxiliary. All Branch Auxiliaries participated and had as their guests, leaders from their respective areas.

Nurse Recruitment was highlighted by the newly established Nursing Scholarship Fund created by the Woman's Auxiliary to the Chicago Medical Society. Each Branch Auxiliary will be entitled to share the proceeds from the Luncheon and Fashion Show held at Marshall Field and Company, March 3, 1955, in the amount of $100.00, for a scholarship or loan in the Hospital Training School of their choice. Two Branches maintain Loan Funds, other Branches are supporting twelve Scholarships, making a total of 22 Scholarships that will be available in Cook County. Two Future Nurses Clubs were organized and approximately 400 prospective students were contacted.

The Auxiliary's participation in the Chicago Medical Society Clinical Conference was far above any expectations. The registration was 661. The Hospitality room was open each day where the women had an opportunity to meet their friends and get acquainted with visiting doctors' wives. 138 attended the Tea and 619 tickets were sold for the Luncheon and Fashion Show.

Today's Health magazine and the Bulletin were also supported. Our contribution to the Benevolence Fund to date is $1,972.00. The contribution to the American Medical Education Fund to date is $450.00. Our Auxiliary members as individuals participate in many Hospital and Community projects.

THE VETERANS SERVICE COMMITTEE

The Veterans Service Committee has been in existence for many years having many problems following major conflicts.

These problems were serious in 1946, '47 and '48 having dwindled to very few at this date.

Hospital connections no longer worry the veteran—office space is no problem. Locations are seeking physicians, rather than the physician seeking the location. All in all, it seems the Veteran of the Armed Services has few problems these days. Some of the members of this Committee can report that they are more occupied with making work for future Veterans Service Committees, mainly by making new Veterans under the Doctors Draft law.

Possibly the greatest controversial subject of the Veteran is that of medical care. This does not come within the scope of this committee.

Respectfully submitted,

F. Lee Stone, M. D.; R. C. Oldfield, M. D.;
John Lester Reichert, M. D.; Earl H. Blair, M. D.
H. Close Hesseltine, M. D.; E. A. Piszczek, M. D.
Councilors, Third District.

FOURTH DISTRICT

To the Members of The House of Delegates:

The activities of the medical societies of the various counties in the fourth district have proceeded about as usual during the past year.

For your information it might be stated that the fourth district is composed of the following counties: Peoria, Rock Island, Henry, McDonough, Fulton, Stark, Knox, Schuyler, Henderson, Mercer, Hancock, and Warren. Each of these twelve counties is represented by a society except that Stark county is united with Henry county as one society. These eleven societies are represented in the house of delegates by fourteen delegates, Rock Island society and Peoria society having two and three delegates respectively.

We have had two Postgraduate Conferences, one in Rock Island and one in Galesburg. Each of these was very well attended and the scientific programs were excellent. The Fourth District will next year make added effort to secure better attendance at the conferences and will do so in the manner suggested by the Postgraduate Conference Committee.

Our district has been disturbed by the number of mal-practice suits instituted during the past year. For several years this district had no such suits, and now we have at least four; these, as we have been led to think, are not too valid as to the claim of the plaintiff, but nevertheless they are suits and are therefore disturbing.

The Councilor has, before the various units, stressed the need and the efficiency of active committees at the county level for handling "grievances" and the "Advisory Committee" to the Illinois Public Aid Commission. The activities of the other committees have not been overlooked and the publishing of the second volume of the History of Medical Practice in Illinois has been brought to the attention of the societies and their individual members very forcibly.

A very pleasant task assigned to the Councilor is the presentation of the Fifty Year certificates and pins to the members of our profession who have practiced long enough to attain this distinction. The pattern of such procedure in the Fourth District does not vary much from that of the other districts. At some presentations the affair is made quite elaborate and becomes the climax of a real celebration; at others the presentation is made as a part of a regular meeting. One of the former type was held in Fulton County on September 26, 1954. when Dr. Robert T. Ewan was honored The whole community gathered at noon for a picnic dinner. Then in the afternoon a very distinctive parade of floats made by organizations in Lewistown, by schools, by stores, etc., and a great number of Dr. Ewan's "babies" passed in review before the good Doctor to do him honor. Again in the evening a large audience gathered to show their love and respect for this man when he received an award of citizenship, and his certificate and pin from the Illinois State Medical Society.

It is with deep regret that we record the death of Dr. Lee T. Hoyt of Roseville on June 16, 1954. Dr. Hoyt was the physician who received in 1948 the award from the Illinois State Medical Society as the most outstanding practitioner in the State for that year. This was the first time this award was given by our Society and it was recorded with considerable space in the news both locally in our state and nationally. The honor was well bestowed and accepted by Dr. Hoyt most humbly. It was through the efforts of Dr. Hoyt as chairman of the Committee on Nutrition that great impetus was given this particular subject officially in our State Society and also in the presentation of this subject to the students in our medical schools in Chicago.

This Councilor has had the privilege and honor of serving on the following committees during the year: as a member of the Advisory Committee to the Illinois Public Aid Commission; as a member of the History Committee; as a member of the committee to select a location for the Chicago office of the Illinois State Medical Society; and as Chairman of the Educational Committee. In this work as Councilor he has not been absent from any Council meeting during the year.

Association in this official capacity with other members of the Council has been very pleasant indeed for the Councilor of the Fourth District. It is his sincere desire to express his thankfulness.

Respectfully submitted,

Charles P. Blair, M. D.,
Councilor, Fourth District.

FIFTH DISTRICT

To the Members of the House of Delegates:

The Fifth Councilor District has seen during 1954-55 cooperative activity with all component societies. Regular meetings have been held by each group and in most instances scientific programs included with business meetings. It is of interest to note that there is an increasing desire of the members at large to know what is happening in medico-economic and medico-sociologic problems throughout the nation, as well as to be better informed of the activities of the State Medical Society relative to these and other problems. Certainly there is an increasing awareness that physicians must become more interested and participate in the facets of medicine other than scientific and therapeutic.

Springfield has been the site of numerous conferences and meetings which have reflected credit to the State Medical Society as a whole. Probably the most outstanding event was the State Society's reception and dinner honoring the Illinois State Department of Public Health and its competent director for 14 years, Dr. Roland R. Cross, on February 8. To this meeting were invited all the state legislators, numerous state officials and other guests. Over 310 attended this event where, in addition to honoring the Health Department, the state legislators and their predecessors were publicly thanked and credited with providing the necessary finances to enable Illinois to have such a preeminent Department of Health. Certificates of merit and appreciation were presented to Dr. Cross and the department by Dr. Arkell M. Vaughn, president, and Dr. Joseph T. O'Neill, chairman of the Council, respectively. It has been stated that this is the first time a state medical society has ever so honored a public health department in this manner.

The Secretaries' Conference held in Springfield on March 27 had an attendance of 131, despite a snow storm two days previously and continued threatening weather. The excellent work of the Conference Officers in designing a program dealing with current problems of county secretaries is to be highly commended. At this meeting Dr. Russell Roth of Erie, Pennsylvania, was an out-of-state speaker. The members voted to hold the 1956 Conference again in Springfield.

The Auxiliary of the Sangamon County Medical Society rendered for the sixth consecutive year an invaluable service to the doctors of this state by staffing the medical exhibit, which was this year doubled in size, at the 1954 Illinois State Fair. Considering that the exhibit was open throughout the day from morning until eight o'clock for a period of ten days, great credit is due these ladies, and their participation serves as an excellent example of the assistance the Auxiliary can be to the medical profession. Many thousands of people visited this display containing four diversified exhibits from the American Medical Association, "Alcohol Tests for Drinking Drivers," "Home Accidents," "Food Facts, Fads and Fallacies," and "Sinus Trouble." In addition, continuous medical movies were shown and four varieties of pamphlets distributed. Having watched the pro-

gress and growth of this project closely during the past five years, I am convinced that this is an excellent and very economical way of bringing medicine's story to the public.

Since the opening of the 69th General Assembly in January, much activity has taken place on the legislative front. For keeping abreast of current legislative problems and informing members of the Society of these by the inauguration of his Springfield News Letter, I desire to pay high tribute to the Society's Associate Counsel, Mr. Walter Oblinger. Unquestionably, many situations concerning medical legislation are yet to arise and will demand participation of members of the Society, in which I shall assist in any possible way.

From the scientific standpoint, three postgraduate conference have been held in the Fifth District, at Lincoln, Bloomington and Springfield, all of which were well attended. Additional conferences were anticipated at other locations but conflict of dates prevented their completion.

Seven Fifty Year Club certificates were officially presented at regular county medical society meetings. The gratitude and appreciation of the recipients of these certificates is constantly an inspiration, not only to the county society members but to this Councilor as well.

In addition to attending all Council meetings and several State Postgraduate Conferences, I have also served as a member of the Editorial Board of the Illinois Medical Journal and as a member of the Liaison Committee on Medical Education, Veterans Medical Affairs committee, the Constitution and By-Laws Committee, the Voluntary Prepayment Plans for Medical and Surgical Care Committee, and the Postgraduate Educational Committee. Also, some committee meetings and sessions of the House of Delegates were attended during the AMA Annual Session in San Francisco.

I desire to publicly thank the officers and members of the component societies of this district for their courtesy and cooperation during the past year. I gratefully appreciate the cordial receptions which have been accorded me at all meetings.

Respectfully submitted,
JACOB E. REISCH, M. D., *Councilor, Fifth District.*

SIXTH DISTRICT

TO THE MEMBERS OF THE HOUSE OF DELEGATES:

The medical affairs of the Sixth Councilor District have apparently been going along smoothly, although some dissatisfaction with the administration of the IPAC has been voiced in certain localities, particularly with those physicians who dispense drugs.

Greene County was visited in September where a program on Anti-Hypertensive Drugs was presented. The program was well received, holding the attention of the members, and precipitated considerable discussion.

A 50 Year Certificate was presented to Dr. Russell Wells of Pleasant Hill in December at Pittsfield. Dr. Wells did not want a large meeting, just his confreres in Pike-Calhoun Counties.

A postgraduate meeting was held in Jacksonville on March 10, 1955; the afternoon session at the Morgan County Tuberculosis Sanatorium, and the evening session at the Norbury Sanitorium. Northwestern University presented the program with about 60 physicians in attendance, who showed marked interest. The majority attended both sessions.

A Postgraduate meeting held in the Spring of 1954 at Carlinville was well attended. The program was the first to be held in Carlinville, and the Macoupin County Society plans to hold another program next year.

I will attend meetings at Quincy, Carlinville and probably Madison County during April.

Respectfully submitted,
W. H. NEWCOMB, M. D., *Councilor, Sixth District.*

SEVENTH DISTRICT

TO THE MEMBERS OF THE HOUSE OF DELEGATES:

The Seventh District has enjoyed a satisfactory year and progress has been constant throughout the eleven constituent Societies in medical and community activities.

During the year two Postgraduate Conferences were held. The Macon County Medical Society was host to the conference given by the Michael Reese Hospital Staff, October 21st, 1954 at the Hotel Orlando in Decatur. The second conference was held in Centralia at the Meadow Woods Country Club, the Marion County Medical Society doing the honors. Faculty members of the University of Chicago, Department of Medicine, gave a stimulating program. The attendance was excellent at both meetings. The Woman's Auxiliary of Macon and Marion County Medical Societies very graciously extended hospitality to the wives of physicians attending the Conferences.

Two major Conferences are planned, one for Fayette County at Vandalia in the fall of 1955 and for Effingham County at Effingham in the spring of 1956.

Postgraduate Conferences have become exceedingly popular and in great demand, so much so that the schedule for the State for the year of 1955 has been filled.

There has been completion of two new hospitals in the Seventh District. Taylorville celebrated the opening of St. Vincents Hospital, a $2,500,000 structure, December 31, 1954. The $1,500,000 Fayette County Hospital was opened at Vandalia January 3, 1955, at which time more than ten thousand people passed through its doors to view this modern building. The Decatur and Macon County Hospital will formally open its $1,500,000 wing housing surgical, obstetrical, orthopedic, urological, emergency, radiology and pathology departments April 1, 1955. The part of the main hospital that served the obstetrical department will be remodeled and used for the hospitalization of the chronically ill and senile patients. Hill-Burton Act Funds were alloted to these three projects.

One fifty year award was presented to Dr. Henry C. Turney of Shelbyville on September 14, 1954 in the Shelby County Community Hospital at a dinner held in Dr. Turney's honor by the Shelby County Medical Society. The awarding of the Fifty Year pin and certificate continues to be one of the pleasant duties in the province of this Councilor. Each occasion is different and unique, but in all there is a glow of good fellowship and pride in one's profession.

During the past year there were two disciplinary problems that required the Councilor's attention.

A pilot insurance study meeting the standards of the Macon County Medical Society Insurance Committee resulted satisfactorily. This was made possible by the creation of a Citizens Committee on Insurance whose representatives included persons from hospital staffs, auxiliaries, churches of all denominations, labor, industry, the press and medicine.

Blue Cross and Blue Shield met the insurance program standards and were the only applicants to the program. The program was submitted to insurance agencies at large for open competition. This carefully planned and successful study was preceded by nearly three years of prodigious preliminary ground work. As a public relations project this program was given much favorable publicity and the public response was both excellent and most gratifying.

This Councilor has attended all Council meetings and expects to have visited all Societies within the Seventh District providing the individual society meetings will permit before the Illinois State Medical Society annual meeting in May 1955.

At this time I wish to express my sincere thanks to all of the Societies in the Seventh District for their cooperation and friendly gestures shown me at all times. The duties are truly a pleasure. Last, but certainly not the least, my congratulations to the Woman's Auxiliaries. They are really our Public Relations Ambassadresses at all times.

Respectfully submitted,
ARTHUR F. GOODYEAR, M. D., *Councilor, Seventh District.*

EIGHTH DISTRICT

TO THE MEMBERS OF THE HOUSE OF DELEGATES:

The past year has seen several interesting developments in the Eighth District. Prominent on this list of developments is the problem of graduate nurse training within our hospitals. One hospital in the Eighth District was virtually forced to close its nurses' training school because of constant upgrading on the part of the Department of Nursing within the Department of Registration and Education. A secondary factor was the inability to find trained teachers.

In another instance in our district, constant upgrading lead to the threat that the Board of Directors of a hospital would close the nurses training school. This threat has not yet been invoked but is just around the corner. A continuation of our nurses' training schools within the Eighth District is the only answer to our bedside nursing care, as we see it. It is this Councilor's opinion that nearly all the physicians in this area want to keep their nurses' training schools in operation despite efforts of the League of Nursing Education and of our State Department of Registration and Education to the contrary. These physicians are interested in educating young women to perform useful and needed tasks within our own communities and wherever they might go in this great land of ours. This problem is so vital that it is hoped that it is adequately ventilated at our State Meeting.

The problem of postgraduate education is an ever present one. From reports I have received, the counties who use the "circuit rider" type of program are eminently satisfied with it and want the "circuit rider" or his successor to return next year. It is this Councilor's opinion that in some areas that type of postgraduate education is the best that can possibly be devised.

During the year, two general afternoon and evening postgraduate sessions were held in the southern part of the district. One was held in Olney and one in Mattoon. The programs were of excellent quality, the discussion quite pointed, and, I believe, a time most profitable to the physicians and to their patients in those areas.

In the northeast corner of our district, the Academy of General Practice has maintained a series of lectureships during the last three years which certainly has functioned well as a mechanism of postgraduate education. These lectures have been well-received and well-attended.

The problem of tax-supported medical care has brought its usual number of headaches. It is this Councilor's opinion that the profession is becoming more and more aware of its responsibility in connection with the operation of these tax-supported programs. Most of us feel and know that it is a government type of operated medicine, but its basic management depends upon the cooperation of the profession. With all of its flaws, the profession and the public would both be much worse off were the programs operated from Springfield without any local advice.

No serious intra-society problems have arisen during the year that have been called to the attention of the Councilor. The year has been one of substantial progress in the care of the sick with the lowest mortality and morbidity figures we have ever had.

Respectfully submitted,
HARLAN ENGLISH, M. D., *Councilor, Eighth District.*

NINTH DISTRICT

TO THE MEMBERS OF THE HOUSE OF DELEGATES:

Your councilor is very appreciative of the fine professional spirit and cooperation of the Doctors in the Ninth District.

There have been a few problems in the various County Societies, such as staff membership in Hospitals, the ever present problems of the IPAC and a few matters of less importance.

The following official functions were attended by your councilor: the meeting with the legislators in Springfield, honoring Dr. Cross of the State Health Department. The dinner and program honoring Dr. Andy Hall in Mt. Vernon. All meetings of the Council in Chicago have been attended regularly.

There are apparently 6 Doctors in the Ninth District who are eligible for the 50 Year Club. Not all of these certificates have been presented, since this action is to be initiated by the local county medical society.

There are many problems confronting the Doctors of Southern Illinois as well as the rest of the State.

First I think we should be conscious of the ever increasing cost of medical care. This not only includes professional services but also the steady increase in the cost of hospital care.

County medical societies in the organizational structure, can help in the control of these problems.

It would be a great advantage if one or two meetings a year could be devoted entirely to medical economics, especially with reference to such items as professional fees for services; length of hospital stay; minimal use of laboratory facilities, consistent with good medical care; abuse in the use of expensive drugs; and last but not least a very careful appraisal of the patient's ability to pay.

Second, the ever increasing encroachment on the medical profession by federal and state government as well as other agencies.

We are now in our practice, dealing with a third party, especially with reference to payment for professional services. In some instances this is good and in others bad. The volume of this type of practice is increasing constantly. This situation is one of the very important factors in the rising costs of medical care, in view of the fact that people lose sight of their own financial responsibility and tend to seek an excessive amount of medical care.

There have been no Postgraduate Conferences in the Ninth District so far this year. I believe two have been scheduled however.

The few counties who have Woman's Auxiliary organizations have been very active. The Saline County Auxiliary has done a remarkably good job with reference to our local blood bank.

We are sorry to report the death of one of our Past Presidents of the Saline County Medical Society, Dr. A. J. Butner.

I would like to suggest that in the future we in the Southern part of the State have some joint county medical society meetings. It is my opinion that this would help us all to become better acquainted, and have a better understanding of each others' problems.

Respectfully submitted.
B. E. MONTGOMERY, M. D., *Councilor Ninth District.*

TENTH DISTRICT

To the Members of the House of Delegates:

It is with a great deal of pleasure that I report that the Tenth Councilor District has gone through a year with disgustingly healthy behaviour. There have only been a few flurries of discontent among the membership, certainly far below the usual average of malcontent of doctors among themselves.

You, of course, know there have been some decisions handed down from AMA and Illinois State Medical Society in reference to a number of subjects which I hope you have all kept yourselves familiar with. For example, the decision of the Judicial Council of the AMA in reference to the present status of medical ethics. I think the course of professional conduct is pretty well defined as far as billing procedures are concerned. However, there is one phase of medical ethics which we are probably neglecting and that is our own professional conduct towards each other. When it comes to medical ethics our conduct towards patients and our financial arrangements with each other and the patients are of primary importance, but there are other phases of medical ethics which we should not lose sight of. Not one of us is so perfect that we can talk about the errors of others. We must remember that regardless of creed or professional accomplishments we are all members of the medical fraternity and we sometimes forget medical ethics as it should apply in our conduct with fellow practitioners in regard to their opinions and rights; even a disapproving "grunt" could get one of our professional members involved in a law suit. So, my battle cry at the present time is "let's all of us treat each other with the respect with which all doctors should be treated."

There was a postgraduate conference held at Cairo on November 17, 1954, which was of the panel type. It was very successful in that there was an excellent program presented and very excellent cooperation on the part of the committee. The hospitality provided by the Alexander and Pulaski County group was superb. There were two disappointments: the goose hunt was a sorry failure and the attendance at the meeting was a little bit below expectations, however, it was not too badly attended. There will be another postgraduate meeting within the district which will be held before you read this report, therefore I cannot report on it at this writing as this report is due at the printers before the meeting occurs. This is the scheduled postgraduate conference to be held at St. Mary's Hospital in East St. Louis on April 7, 1955.

It is my observation that for the most part medical societies are continuing to be active in their efforts. Most of the societies meet regularly. Those that have been a little bit dilatory in the past year or two have begun to show more conscientious activity and I can report everything in pretty good shape in the Tenth Councilor District. Some rural areas are, of course, short of doctors. Many of us are professionally very busy—too busy; althongh we hope to keep struggling along and hold up our end of the obligation to ourselves, to our society, and to the public.

Respectfully submitted,

Willard W. Fullerton, M. D.,
Councilor, Tenth District.

ELEVENTH DISTRICT

To the Members of the House of Delegates:

Conditions in the Eleventh Councilor District are flourishing. All of the county societies are vigorous and alive with enthusiastic regular meetings.

Several members have received Fifty Year Club certificates during the fiscal year and more are on the eligible list.

This district has the honor of having the baby county society in the state, in fact the first new county organization in the past 50 years. On April 27, the Kendall County Medical Society was presented with a charter by the officers of the Illinois State Medical Society at Yorkville.

The annual Postgraduate Meeting for the district was held in Kankakee in March with a good attendance and an excellent program. Smaller meetings have been held in Watseka.

The residents of Ford County held a "Dr. Peterson Day" at Paxton, in honor of Dr. M. D. E. Peterson, who has completed 50 years of service in that community. The reception and dinner were well attended by the people of the area.

Your Councilor has attended all of the meetings of the Council, except one which occurred while he was in Europe as a representative of the American Medical Association. He has been active in committee work for the society, particularly on the Finance and Public Relations Committees. He wishes to thank the officers of the component societies for their cooperation the past year. His other duties have made it impossible to visit all of the component societies although he has been present at most of them.

Your Councilor wishes to thank the Secretary and his staff for their many courtesies during the past year, as well as their cooperation at all times.

Respectfully submitted,

E. S. Hamilton, M. D.
Councilor, Eleventh District.

COUNCILOR-AT-LARGE

To the Members of the House of Delegates:

The constitution of our Illinois State Medical Society provides a place for the immediate Past President.

Artcle VI—"The Council"—Section 5, reads as follows: "Each year the retiring President of this Society shall automatically become a member of the Council for a period of one year. He shall be designated as a 'Councilor-at-Large'."

It was in this capacity that your immediate Past President functioned during the past year. It gives him an opportunity to observe from the sidelines the "Council Proper" in action. This observation has convinced him more than ever that our State Society is in good hands.

In a recent Council meeting definite action was taken toward solving the problem of our Chicago office, i. e., in securing space where all the Society's activities will be in one suite of rooms. This is a forward step.

It has been our privilege, too, to observe the national and international trends. This we have done with considerable trepidation. The medical profession must not relax its vigil, lest *it* with our great country, be overwhelmed by socialism.

Our support of the American Medical Education Foundation is antisocialistic. It is preserving free and unfettered medical service for America.

It has been a great pleasure and honor for your Councilor-at-Large to have been a member of the official family of the Illinois State Medical Society during the past three years. For this great honor, he shall ever be grateful.

Respectfully submitted,

Willis I. Lewis, M. D., *Councilor-at-Large.*

Reports of Standing Committees

MEDICAL SERVICE AND PUBLIC RELATIONS

To the Members of the House of Delegates:

The report of this committee for this year will be a very much abbreviated one, inasmuch as Mr. James C. Leary, our Director of Public Relations, died on April 12, 1955.

James C. Leary was employed by the Illinois State Medical Society as Public Relations Director in 1945, having succeeded Lawrence C. Salter & Associates. It is perhaps needless to remind the House of Delegates, but only fair to recall for them, the fact that he rendered valuable service to the Illinois State Medical Society and organized medicine.

He was an enthusiastic, indefatigable, ardent worker, who was frequently called upon to do the "leg work" for the society. The service rendered by him was not only confined to the public relations committee, but extended into almost every component part of the state organization. He likewise rendered valuable service and advice to the auxiliary organizations. Never so far as is known, did he refuse or fail to render advice or service when called upon. His gift as a writer is well known to all of you, and was known to many people during his newspaper career. This unique gift was frequently called into use in connection with helping many in the state society writing technical and economic papers, or presentations. He was always able to improve a paper, and write a little more than the basic facts of a medical economic situation. He was loyal to the medical profession and particularly to the Illinois State Medical Society.

His passing will leave a difficult place to fill.

He had been preparing notes for this report at the time of his death, but had not dictated them. Therefore, this report is being made without the benefit of his reporting and advice. While an accurate record has been kept of the activities of his office, as he had not dictated or transcribed his notes, the committee hereby acknowledges its inability to write in the flowing, clear-cut intelligent manner of Mr. Leary.

General Data:

The committee has held five meetings since its last report.

The House of Delegates was informed last year of Mr. John W. Neal's resignation as legal counsel and legislative representative, as of January 1, 1954. Fortunately for the Illinois State Medical Society, at the Council's request, Mr. Neal has continued to serve the society in the capacity of general counsel.

The services of Mr. Walter L. Oblinger of Springfield, as associate counsel and legislative representative were obtained as of June 1, 1954. The committee feels that the society is to be congratulated upon having obtained the services of Mr. Oblinger. He has already shown a keen insight into his duties and shows a remarkable understanding of the many problems of the medical profession.

The state society has also been fortunate in that Mr. Leary was able to obtain the services of Mrs. Clara Mai Rutherford, who has shown a remarkable aptitude, initiative and executive ability in carrying on the many important and diverse activities of the public relations office during the absence and illness of Mr. Leary. Mrs. Rutherford has been invaluable in this regard.

There has never been any intention on the part of the committee to insist upon or compel any individual, or group, or county society to accept or act upon the suggestions of this committee. Instead, help has been offered in good faith, as well as a continuing effort to convince every member that maintaining good public relations is part of his duty to himself, his profession and his community.

Many other activities have been carried on in the office of the public relations director, which are far too numerous to enumerate, or to recall in detail. Certainly members of the House of Delegates who are active in medical organization work appreciate the fact that there are many contacts to make, errands to run, and hours to spend that may never be apparent on the surface, nor show on the record.

Many conferences were attended by Mr. Leary. Among them were the conferences on the program of immunization suggested by the National Foundation for Poliomyelitis. As a result of these conferences, it was necessary to write releases regarding the proposed program for the press, describing the attitude of the medical profession in Illinois and Cook County in regard to the proposed program. Much time and effort was spent in this regard, and incidentally, the preparation of a news release for the Chicago Medical Society in connection with this project was Mr. Leary's last act. He died after barely completing the writing of this release.

The Committee at the suggestion of Mr. Leary recommended to the Council that awards be made by the Illinois State Medical Society annually. These awards are to be known as Annual Health Progress Awards. The awards shall be given to the individual and the organization which shall be selected as having contributed most substantially to the health progress of the people of Illinois, or any subdivision thereof during the preceding year.

The Committee and the Public Relations Director have felt that this committee and the staff should be available and render service to any county medical society in the state. Because of that fact, as well as the location of the Chicago Medical Society, a very large amount of service has been rendered to the Chicago Medical Society in connection with public relations.

A very cordial feeling exists between the Chicago Medical Society and the public relations office of the state society. There have been no circumscribed limits to the potential interest, or to the service rendered. The Committee is of the opinion that its function is primarily to act as a goad or catalyst to further public relations activities in the director's office and in the county society, where it is the most effective and most essential.

We want to ask of every member of the House of Delegates, as well as every officer of the state society and of the component societies, an ever greater level of interest and activity in the work of this committee. Public relations and legislative representation are not functions that can be delegated to a committee and forgotten. They require the active cooperation of every society and every individual member at all times. Our staff cannot perform these functions. All they can do is use their experience and contacts to organize and bring to bear the weight of influence of the medical profession in the community, and that means individual participation by every member. If medicine is to win its fight against Socialism, the real enemy of the profession and of our country as we know it, every one of us must give all he can of time, energy, experience and personal influences. Each delegate and each councilor should take that message back to his home society and keep hammering it home.

North Central District Blood Bank Clearing House

A release was written in which plans for a Clearing House for Blood Banks in an 11-state area was announced. 519 copies were mailed to the daily papers in Indiana, Iowa, Michigan, Minnesota, Missouri, Nebraska, North Dakota, South Dakota, Kansas, Wisconsin, the Chicago daily and weekly newspapers, and also to the members of the Illinois General Assembly.

The Woman's Auxiliary:

Our Public Relations Director had always felt that the Auxiliary was a very vital and important part of the organization. His staff was always available to the Auxiliary for any help that could be given, such as mimeographing and mailing letters of chairmen to presidents, legislative chairmen, county and branch presidents, and county and branch bulletin chairmen.

Help was given the Auxiliary to the Chicago Medical Society in publicizing their meetings in the Chicago daily and weekly newspapers.

Publicity releases were prepared and mailed for the Auxiliary's Public Relations Day Luncheon, which was held in November of 1954.

Chicago Medical Society:

In June of 1954 a Statement for the Chicago Medical Society was prepared by this office, answering the allegations originating in the Chicago Board of Health regarding excessive infant mortality at Cook County Hospital.

The press and publicity for the 11th Annual Clinical Conference of the Chicago Medical Society was done in the office of the Public Relations Director. This included writing speakers, asking for advance copies of their papers, from which releases were prepared. Mr. Leary attended the Conference, and Mrs. Ruthertord had the responsibility of handling the press room.

Outstandig G. P. of The Year:

Material was gathered in Rushville from friends and relatives in regard to Henry O. Munson, M. D., who was deemed the Outstanding G. P. of the Year. A 12-page leather-bound book for presentation to the American Medical Association was prepared. This work was done on very short notice, as the deadline was very close. 192 copies, plus mats and pictures, were mailed in connection with this release.

Committee on Nutrition:

466 copies of a 4-page release entitled "Medical Society Issues Warning on Self-Run Low Salt Diets" were prepared and mailed for the Committee on Nutrition. This release obtained very favorable publicity in the national newspapers, as well at Time Magazine and Science Service.

Committee on Industrial Health:

Assistance was given the Committee on Industrial Health in preparing a release "Medical Relations under Workmen's Compensation in Illinois", as well as more than 200 copies of a release mailed to Illinois papers, radio and television stations in regard to the fact that the Illinois State Medical Society was seeking evidence of unethical actions in compensation cases.

In addition to the questionnaire that had been sent out by the secretary's office to the members of the Illinois State Medical Society, regarding their willingness to participate in compensation work, the replies were directed to this office.

When delivery had failed, the letters were returned to this office, and were forwarded to Monmouth for the purpose of correcting the mailing list. For a period of two weeks or more, this work required more than an hour daily.

Postgraduate Education Committee:

The work in connection with the Postgraduate Conferences has been carried on in the office of the Public Relations Director. This entailed correspondence with county medical society secretaries, councilors, faculties of medical schools, hospitals, and individual physicians.

Programs have been set up in detail in this office, under the supervision of Dr. Louis R. Limarzi, chairman of the committee; news releases have been prepared in the instance of every postgraduate conference.

This procedure was followed for the 11 major and 3 small conferences.

Poliomyelitis Vaccine Program:

The statements concerning this program for the press were prepared in the office of the Director of Public Relations. One statement was prepared by Dr. John L. Reichert, and the other by Mr. Leary. Also a letter concerning the plan of the Chicago Medical Society and the Illinois State Medical Society, with a School Certification of Grade for Poliomyelitis Vaccine Program, was sent to Dr. Roland R. Cross, Director of the Illinois Department of Public Health.

Dinner Honoring Roland R. Cross, M. D.:

Part of the detail of a dinner honoring Roland R. Cross, M. D., on February 8, 1955, was handled by the Public Relations office. Seventy-five letters of invitation to family physicians of legislators to attend the dinner, letters to branch secretaries, letters to county medical secretaries, as well as preparing and mailing 205 releases.

Legislative and Governmental Affairs:

Cards and addressograph plates for all the members of the 69th General Assembly of Illinois were prepared; a mimeographed questionnaire concerning the state legislators was prepared in this office; as much of the information as this office was able to gather was filled in on the questionnaire, then mailed with a detailed letter of instruction to the county and branch secretaries, to be completed by either the county or branch secretary, or the family physician. In a few instances, the county or branch secretary failed to read, or else properly interpret the letter that was sent with the questionnaire, and the questionnaire was submitted to the legislator personally. In these instances, some disturbance occurred which required explanations and apologies to a legislator. It is believed, however, no permanent harm resulted.

From various sources, this office was able to obtain the names of 69 family physicians. Cards and addressograph plates were made up for this group, who were sent pertinent information on the legislator from time to time. When the completed questionnaires were returned to this office, copies were typed and sent to Mr. Walter L. Oblinger and Dr. Camp. This office has kept a detailed record in bound volumes on the information received.

The Springfield Letter, written by Mr. Walter L. Oblinger, was mimeographed and mailed from the office of the Public Relations Director.

1955 is a legislative year in Illinois, and our General Assembly is now in session. As a result of the "Blue Ballot" referendum last November, the legislature is now struggling with the politically-charged task of reapportioning the state's legislative districts. Although the Illinois Constitution directs the General Assembly to reapportion the state every ten years, political considerations have prevented the job from actually being done since 1901. The shift in population toward northeastern Illinois has caused that area of the state to be greatly under-represented in the legislature. If the General Assembly should fail at this session to adopt a plan of reapportionment, a commission will be appointed to do the job. Should such a commission fail to accomplish its purpose, all state senators and representatives would be elected at-large—a prospect which is most disagreeable to local political leaders.

From the standpoint of medical legislation, it has been a relatively quiet session so far, although this situation could change very quickly. No new osteopathic or unlicensed chiropractic legislation has yet been introduced, but it is quite possible that both groups will be heard from soon. On April 12, the Supreme Court of Illinois rendered an opinion in the important case entitled Chicago College of Osteopathy vs. Noble J. Puffer, in which the school mentioned seeks approval on a par with Class A medical schools. The Supreme Court agreed that the school should have been approved, and concluded its opinion as follows:

"The grounds for denying recognition to the plaintiff college are all invalid, therefore, at the time of said order (1951) by the Department the plaintiff was qualified as a college reputable and in good standing whose graduates are eligible to take the examination for a license to practice medicine in all its branches in Illinois. The judgment of the Appellate Court is affirmed and the cause is remanded to the Department with directions to expeditiously determine whether any changes have occurred subsequent to that time which justify withholding approval. Said determination is ordered to be

made with the object of effectuating the manifest intention of the legislature as elaborated in this opinion."

It is quite likely that the opinion of the Supreme Court will precipitate the introduction of new osteopathic legislation. If such is introduced, it will doubtless propose the establishment of a separate osteopathic examining committee, and permit osteopaths to practice medicine and surgery. It also seems probable that the unlicensed chiropractors will soon offer their perennial bill to give themselves a license.

Senate Bills 247 and 248 to revise and improve our Coroner System is now pending, and should be ready for passage by the Senate very soon. Senate Bill 171, which would make citizenship mandatory on the part of applicants for licenses to practice medicine, is being held in committee, pending the working out of amendments requested by the Welfare Department.

Numerous other bills of medical interest are pending, but can be mentioned only briefly. They would: restrict the sale of hypodermic needles and syringes; require the pasteurization of all milk and milk products; greatly expand mental health services; permit absentee voting by persons who are sick or disabled; enlarge the State Tuberculosis Hospital at Mt. Vernon; increase the penalties for unauthorized medical practice; require ambulance drivers to be trained in first aid; require physicians to report all cases of blindness to the Department of Public Health; obtain Salk polio vaccine at State expense; exempt certain school children on religious grounds from receiving "instructions in diseases", hygiene and sanitation excepted; requiring blood tests to establish paternity; increase penalties for narcotics violators; make numerous changes in the workmen's compensation laws; extend unemployment compensation to disabled workers; create a fair employment practices commission; etc.

The previous General Assembly (1953) created a legislative commission to investigate Krebiozen in relation to the University of Illinois. The prolonged and bitter hearings extended through the entire year, and the Chicago Medical Society, one of the alleged "conspirators" against Dr. Ivy and his associates, was represented throughout the hearings by John W. Neal, General Counsel for this Society. In early 1954, the Commission issued an interim report which found, among other things that there was no evidence of any "medical conspiracy", a charge which seemed ridiculous from the outset. Although it is presumed that the Commission will make a final report at this legislative session, none has been offered as yet.

Legislative affairs are being supervised for the committee by Walter L. Oblinger, associate counsel for the Society. The "Springfield Letter", which he writes weekly has proved very popular, and the mailing list for it now exceeds 500.

On the national scene, a great deal of health legislation is pending before the Congress. The Washington office of the American Medical Association continues to act for the profession in these matters, and also publishes a weekly newsletter. Among the more than 200 pending bills of medical interest, a few are of the greatest and most far-reaching importance. The administration, through Mrs. Oveta Culp Hobby as its spokesman, is determined to pass its "health reinsurance" bill. A.M.A. continues to oppose it, as it did last year, because it is not needed, it might jeopardize the rapid growth of private plans (and lead to their ultimate capture by government) and invites direct subsidy by government in health matters. Also opposed by A. M. A. are an administration proposal to guarantee mortgages on private health facilities, and the current proposal for federal aid to medical education. It appears that the so-called Bricker Amendment, which would limit the power of the Executive Department to make treaties, will probably not be acted upon this year. Other matters requiring the careful scrutiny of the profession are the questions of medical care for dependents of persons in the military service, of veterans with non-service connected disabilities and a comprehensive survey of the country's problems and facilities in the field of mental health.

Respectfully submitted,

PERCY E. HOPKINS, M. D.
Chairman.
EDWIN S. HAMILTON, M. D.
EVERETT P. COLEMAN, M. D.
EDWARD A. PISZCZEK, M. D.
LEO P. A. SWEENEY, M. D.
Ex-Officio:
ARKELL M. VAUGHN, M. D.
HAROLD M. CAMP, M. D.

Committee on Medical Service and Public Relations.

MEDICO-LEGAL

TO THE MEMBERS OF THE HOUSE OF DELEGATES:

The Medico-Legal Committee of the Illinois State Medical Society met on Sunday, March 13th, 1955, at the Hotel Sherman, and made an informal report to the Council on the same date.

The committee had no specific problems, none having been referred to the committee during the past year, except two (2) inquiries which were answered after consultation with the Society's legal consultant, Mr. John Neal.

The committee is aware of the fact that there are some medico-legal problems pending which may require serious attention of the Society. For example—insurance companies have now discontinued writing policies in two states and there has been reported in some areas in the country, an increase in the number of medical liability suits. Moreover, the size of the suits has been increasing. Many hospitals are having trouble with the liability insurance problem which is not specifically the problem of the medical society and is being studied by the American Hospital Association.

The committee explored the possibility of sending out a questionnaire to all the members of the Society requesting specific information on present or pending suits. It was the opinion of the committee that even if unsigned questionnaires were filled out many doctors would still be reluctant to turn in their experience, and therefore the information obtained would not be reliable or complete.

An inquiry was made to the legal department of the American Medical Association and it was found that the legal department is making a nation-wide survey of the number, sizes and settlements. They stated that they were getting cooperation from the insurance companies, whereas the legal committee was not able to get such reports locally from the insurance companies.

The committee therefore recommends:

1. All members of the Society should take stock of their medical liability problems.
2. The members be again reminded by the Society that most suits have their origin in the "indiscreet" remarks made by members of the medical profession. Another large group has its origin in failure of the doctor to inform his patient as to possible unfavorable results of specific medical conditions.
3. The Society awaits the report from the American Medical Association to determine what the actual number of suits and settlements are in the State of Illinois.

GEORGE C. TURNER, M. D., *Chairman*
A. L. NICKERSON, M. D.,
ARTHUR A. LORING, M. D.,
F. E. BIHSS, M. D.,
EDWARD C. HELFERS, M. D.
RALPH MCREYNOLDS, M. D.
Medico-Legal Committee.

ARCHIVES

To the Members of the House of Delegates:

The Committee has communicated with officials of all County Societies in the State during the last year, and has stressed the importance of collecting and preserving all material pertaining to medical history. Such material relating to the 1900-1950 period is especially important at present, but everything of interest before or after these dates should also be sent to the keeper of our Archives, in the Crerar Library.

Volume II of the History of Medical Practice in Illinois which covers the period between 1850 and 1900 has been completed. The historical items requested above will be needed in compiling any history describing medical practice in Illinois after 1900. Articles concerning individual physicians, medical societies or any activities of any kind in the field of medicine should be sent to Miss Ella Salmonsen, The John Crerar Library, 86 East Randolph St., Chicago 1, Illinois.

It is with great regret that we announce the loss through death of a very active member of this committee, Dr. David J. Davis, who had a coronary occlusion on December 19. Dr. Davis was editor of Volume II of the History of Medical Practice in Illinois and we all will miss his enthusiastic stimulation in the medical history of this State.

Respectfully submitted,
Tom Kirkwood, M. D., *Chairman,*
J. J. Moore, M. D., *Secretary,*
E. H. Weld, M. D.
Committee on Archives.

MEDICAL EDUCATION AND HOSPITALS

To the Members of the House of Delegates:

The problems involved in subjects of such vast importance to the profession as Medical Education and Hospitals are so many and so varied that the committee selected for investigation and report certain of the most pressing.

Mental Hospitals

One of the great health problems that confronts the people of Illinois as well as of the nation concerns the care of the mentally ill. In the year 1954 the folowing institutions and their bed capacities for the care of the mentally ill existed in the state of Illinois.

State Supported Institutions

Name	*Census*
Alton State Hospital	2,334
Anna State Hospital	2,582
Chicago State Hospital	5,466
East Moline State Hospital	2,312
Elgin State Hospital	7,395
Galesburg State Hospital	854
Jacksonville State Hospital	3,785
Kankakee State Hospital	4,550
Manteno State Hospital	8,688
Peoria State Hospital	2,802
Illinois Security Hospital	358
Dixon State School	5,272
Lincoln State School	5,654
Total	52,052

Veterans Administration Hospitals

Veterans Administration Hospital Danville, Illinois (37 beds for tubercular patients) (75 beds for medicine and surgery).	1,559
Veteran's Hospital Downey, Illinois (104 beds for tubercular patients)	2,196
Veteran's Administration Hospital Hines, Illinois	138
Total	3,893

Private Institutions Licensed by the State

Sanitorium Beds	794
Rest Home Beds	351
Psychiatric Beds in General Hospitals	342
Total	1,487

Total Number of Beds for the care of the Mentally Ill in the State of Illinois 57,432

A glance at the above statistics indicates the tremendous responsibility assumed by the state in caring for the mentally ill. The task of carrying out this function of the state government is vested in the Department of Public Welfare currently presided over by Dr. Otto Bettag. What are some of the problems faced by those entrusted with this great task?

Perhaps the most pressing problems arise from insufficient facilities leading to overcrowding. This situation can be remedied only by constructing more hospitals for the care of the mentally ill. If this is to be accomplished the public must be sufficiently aroused to authorize and support more tax supported institutions. Private capital has obviously demonstrated little desire to enter this field. There is no reason to believe that the demand for psychiatric beds will do anything but increase. Actually assuming that the methods of treatment for the mentally ill remain essentially comparable to the present, and assuming that the population growth of Illinois continues at its present rate, there will be a need for an increase of twelve to fifteen hundred beds per year. The medical profession as a whole and not just psychiatrists and politicians must become crusaders for more and better facilities. The people must be led and certainly the medical profession qualifies as a natural leader in this field.

The lack of adequate numbers of competent personnel offers another serious handicap in the care of the mentally ill patients. The Department of Public Welfare has adopted a policy of liberal licensure whereby they are able to obtain professional help, but unfortunately there is a shortage of physicians who are adequately trained in psychiatry. To attract young physicians into this field, salaries must be more attractive, working conditions must be improved and adequate housing facilities may have to be supplied.

As a means of increasing the pool of trained psychiatrists and to aid in the care of patients, good residencies must be offered. Up to the present it has been difficult to induce young physicians to choose psychiatry as a specialty. The results obtained from psychiatric treatment are not immediately forthcoming, are not dramatic and immediately satisfying, so that the young physicians tend to choose a field where the success of their handiwork appears more obvious and directly pleasing. Salary increases at least to the level of those offered by the Veteran's Hospitals might attract to and keep more men in this field of practice.

Certain classes of patients now treated in State Mental Hospitals could probably be better handled in some other manner. Alcoholics for instance are now admitted to psychiatric facilities. Since mental hospitals have no special technique or facilities for treating alcoholics, they could probably be better handled outside the walls or in an outpatient clinic. Another group of patients that find their way into psychiatric institutions are those suffering from cerebral arteriosclerosis. Many of these individuals have no serious psychiatric component and their friends and relatives are using the hospital to obtain custodial care. These patients with the benefit of old age pension, social security and a loving family should be cared for outside the confines of our already over-crowded institutions.

Hospital Consultations

The board of commissioners of the joint commission on accreditation of hospitals has held conferences with interested groups in the medical profession in an attempt to define and clarify the meaning of the term consultation.

It seems to this committee as it undoubtedly does to the accreditation committee, that the only acceptable indication for a consultation is that the patient may derive some real and actual benefit from it. Consultations made for the purpose of maintaining some administrative quota or for the purpose of one physician paying off a debt to another physician might not necessarily have as their basic reason, the best interest of the patient.

The commission considers that seriously ill patients, poor surgical risk patients and those with some obscure disease make up the group that in many instances might be benefited by consultation. They hesitate to specify set conditions that would make a consultation mandatory, and rather depend on the conscience of the attending physician. Nevertheless they do feel that there is a need in most hospitals for some local ground rules, whereby a consultation may be obtained when it becomes apparent that a patient is not doing well and his physician is reluctant to ask for help. This committee feels that it is possible to set up local regulations, but exceedingly difficult to implement them. One of the greatest difficulties in making rules revolves about the question of who has the necessary qualifications to enforce them. "Who is going to decide when the patient is not doing well and a consultation is indicated?" Surely not the lay operators of the hospital. In a University or Government Hospital where the chief of the medical services is in fact the responsible party for all patients, no problem exists. However, in a private hospital the chief of service could have no personal knowledge of patients other than those under his own care. He would have to depend on information transmitted to him from such sources as the resident staff or supervising nurses. The physician who voluntarily neglects to call consultation will pay little attention to a request for consultation by the resident staff or floor supervisor and will resent such suggestions being passed on to the chief of service. This problem is real and therefore not easily solved by rules and regulations. A careful study of case reports in open staff meetings might by the force of general opinion bring about an improvement in this important area of physician-patient relationship.

The commission has defined what they consider an adequate consultation and whom they consider may be employed as a consultant. They state that a consultant must examine the record, do a complete physical examination and record his findings and recommendations which then become a part of the patient's chart. Curb stone discussions are not considered to be consultations. Consulting privileges belong to those members of the staff who possess general or special knowledge obtained either by training and/or experience. Seniority rank on the hospital medical staff or board-certification are not essential requirements nor valid exclusive criteria of competency for consultants.

Medical Schools

The medical schools of Illinois share the trials and tribulations of those throughout the country. They are also contributing to certain changes that appear to be slowly but inevitably evolving. Except in state supported medical schools, there is great difficulty in stretching the school budget to meet the needs of a rapidly advancing and changing system of medical education. Consequently privately endowed medical schools are reaching out for additional sources of revenue. Because medical schools, in order to meet present educational standards, must employ a considerable full time and part time paid clinical faculty at a rather high cost, they are making certain attempts to utilize the services of full time physicians in the care of patients. Money obtained for services rendered patients by the paid faculty is used to supplement what is frequently a grossly inadequate basic salary.

To those who have been away from medical schools for a few years, the division of the faculty must indeed seem strange. Thus, one hears of full time teaching, geographical part time teaching, full time teaching with consulting privileges and part time unpaid teaching carried on by those engaged in the private practice of medicine. This situation has naturally caused medical school faculties to become divided in spirit and in aims into the paid clinical faculty and the part time unpaid clinical faculty.

As mentioned above, in order to meet the increasing salary load medical schools are constantly finding themselves on the verge of or if not in fact, practicing medicine. For instance, medical schools in some areas utilize full time paid teachers as consultants. The fees are paid to a departmental group acting outside the confines of the department but with the stipulation that all monies collected will be contributed to the support of the department. By having the departmental group collect the fees and expend the money, the Medical School is freed of the charge of practicing medicine. This procedure is dangerously close to the medical schools practicing medicine and the whole procedure is at present under study by the American Medical Association.

Full time paid teachers with consulting privileges are quite common. By allowing consulting rights the basic salary paid by the school can be maintained at a considerably lower level. Because of their academic position with a medical school and their availability these physicians conceivably have some advantages over the part time teacher who is engaged in the private practice of medicine. Geographical part time teachers are part time paid teachers and part time practitioners of medicine. They may give a third, a half or perhaps more time to the school. Thus throughout the country there are many schemes and methods by which medical schools are augmenting their budget with funds collected through the activities of their paid faculty.

Medical schools in the Chicago area are still processing many more applications for admission than there are openings in the freshman class. However, at present there are fewer applicants and the caliber of students accepted is noticeably less desirable. In 1947-1948 there were three applicants for each opening in the freshman class throughout the United States. Last year there were only two applicants for each opening. It is not clear as to why fewer students are seeking to make medicine their life's work. Undoubtedly the fact that only one out of every two applicants ultimately places is a deterrent to many aspirants. Possibly good opportunities in business and industry and the threat of state medicine are a minor factor.

The matching system for internes seems to be working quite well both for the student and the hospital. It has not solved the problem of an equitable distribution of internes, but it has indicated those hospitals that make an effort to provide a good and interesting interneship.

The demand for students to function as externes is increasing and in the view of this committee, is creating a disturbing problem in Medical Education. It has been estimated that over 50% and possibly as many as 75% of junior and senior medical students are employed as externes. It is difficult to believe that so many medical students are working because of financial hardships. Because of the lack of adequate medical supervision and the immaturity of their medical experience and judgment, the externe experience is not only of little value but often distinctly detrimental to their training. The substitution of inadequate history writing and unsupervised physical examinations for hours of study causes the student to suffer a great loss in his medical

training. Some medical schools have administratively forbidden their students to work in hospitals as externes. At present all the schools in the Chicago area permit this type of work.

Internes

The interne situation continues to be bad. Very few hospitals are able to obtain anywhere near their required quota of internes. This situation favors an influx of foreign internes. Too often the foreign interne is unable to speak English and because of this handicap he is of little service to the patient, physician, or hospital. Furthermore, it is difficult to comprehend how he benefits much from his internship. It is the feeling of the committee that if the majority of hospitals must depend on foreign internes, there should be some machinery set up for screening them, particularly as regards their ability to speak English.

Some Medical Educators have suggested and actually put into practice the idea of doing away with internes in hospitals associated with medical schools. It is presupposed that these hospitals are adequately staffed with residents. As the situation now stands the interne in a teaching hospital is caught in a trap between the senior student clerk and the resident. The advocates of this system believe that senior clerks with the supervision obtained in a teaching hospital could function as internes and this would free many graduates for internships in non-teaching hospitals. The idea has merit and should be explored by more teaching hospitals. Many students are selecting internships that offer residencies in their field of interest.

Residents

The army still makes it difficult to maintain a good residency program. Too often the resident has tentative orders to enter the military service at some undisclosed time. The fact that his residency may be terminated in a week, a month, or six months does not lend to peace of mind and to unstinted devotion to duty. As in the interneship, there is a shortage of residents and again there is a constant demand for residency service by foreign students. The same language difficulty exists here but seems to be more serious. More is expected of a resident and surely more is expected by the resident. If an adequate means of communication does not exist, little can be accomplished by the resident or his teacher. The committee is aware of one hospital that employs an English teacher for the purpose of enhancing the value of its foreign staff.

Nurses

The committee has nothing new to report on the nursing siuation. There is still an acute shortage of nurses and all the problems existant a year ago are still present. The committee feels that for some reason too few of the recent graduates of nursing schools find their way to the bedside of sick patients. Apparently there are more attractive fields of nursing than those associated with bedside nursing.

George F. O'Brien, M. D.
Chairman.
Harlan English, M. D.,
K. L. Vehe, M. D.
Committee on Medical Education and Hospitals.

MEDICAL BENEVOLENCE

To the Members of the House of Delegates:

The Benevolence Fund is an important program of the Illinois State Medical Society and one in which every member can take justifiable pride. Two dollars from each membership go into this fund to be the means of bringing a little comfort and security to those former members, or their widows, who, through long illnesses or advanced years, are now finding themselves in need of help. The money is available in the Benevolence Fund for those who need it.

Individual cases are determined after an investigation is made. It is of material assistance to the Committee of a physician-member who is well acquainted with the conditions acts as sponsor for the applicant. The time of investigation is shortened considerably if the recommendation of the officers of the component Society is obtained.

It is unfortunate that some applications come in from physicians, or widows of physicians, who have never been members of the Society. These requests must be refused because these applicants are not eligible for benefits under our benevolence plan. Under the regulations established by the House of Delegates, the Committee was given the power to make rules and regulations to determine who shall be entitled to assistance. The Council sets the amount which can be granted monthly by the Committee. However, in unusual cases, in which there seems to be a necessity for an amount greater that that specified, a request must be sent to the Council for final approval of the Committee's recommendations.

The Committee is not permitted, nor would we desire, to publicize the names of any beneficiaries. They are known only to the members of the Committee and those acting as sponsors in the home community. In our reports to the Council no names are mentioned even though we may be asking for permission to increase the grant temporarily, for some obvious reason. The Council asks nothing more than mere facts and never asks the names of the applicants.

Applications are received in the office of Secretary Harold M. Camp who, in turn, sends them on to the Chairman of the Committee to conduct the usual investigation. When this is completed, each member then attaches his recommendation to the form which is then returned to the Secretary's office with the necessary instructions, reporting the action taken on the case by the Committee. The case of any recipient may be re-checked at intervals, if circumstances warrant it.

In the early days of the Benevolence Fund project there were financial worries. When the Plan was set up through the continuous efforts of the late Dr. John S. Nagel, who presented the proposal to the House of Delegates, it was hoped that the income from the earned interest would pay all benefits. But another World War came soon after the Fund was created and there were risks involved in investing trust funds. Government bonds were considered the safest and were decided upon. They carried a small rate of interest that naturally was insufficient to meet the obligations, especially with the increase that prevailed in living costs.

Much help was forthcoming from the Women's Auxiliary. We are indeed grateful and recognize the tremendous amount of financial help given us by them through the years. It pleases us, that they have made the Benevolence Fund one of their major projects. During the past ten or more years they have contributed approximately $45,000.00. In addition to this we have received contributions from some of the members of our Society during this period of time. To keep the Fund growing, two dollars from the dues of each Society member are placed automatically in the fund, as we have stated before, so that the present financial status seems quite satisfactory. We have a cash balnce as of March 1, of $44,295.18 and the amount of Government bonds is $140,000.00. These funds are kept in a separate account in a bank other than the one where the general Society funds are handled. The bank account, as well as the Government bonds, are held in the name of the Illinois State Medical Society Benevolence Fund. Not one cent from the Fund is used for postage, investigations, or for any purpose whatever, other than to make monthly payment to beneficiaries. It is a trust fund in every sense of the word.

Since the inception of the Plan fifteen years ago, there have been 86 beneficiaries. Presently, 33 individuals are receiving monthly benefits. Of these, 10 are physicians and 23 are widows of former members. One application is in process of investigation at the present time.

The Committee misses the guidance of its Chairman this year, Dr. Robert H. Hayes, who is ill and unable to take an active part but from the experience of having served, last year, under his chairmanship, the Committee members are carrying on. The necessary bookkeeping, banking, and other routine duties are carried on in the Secretary's office and the Committee recognizes and is grateful for the vast amount of work done that makes this program so successful.

Words seem inadequate in expressing sincere thanks to Dr. Harold M. Camp, and Wanda Ross, of his office, to the Woman's Auxiliary and others who have contributed so much to a program dedicated to serving the needy members of our profession or their widows.

The future may bring many additional calls for help and an interested, generous group of doctors will respond and welcome the opportunity to serve.

Robert H. Hayes, M. D., *Chairman.*
Norman L. Sheehe, M. D., *Co-Chairman.*
Lee O. Frech, M. D.
Harold M. Camp, M. D., *Secretary.*
Committee on Medical Benevolence.

DR. NORMAN L. SHEEHE: I have a supplementary report, which I wish to submit in addition to the annual report as printed in the Handbook For Delegates.

With the approval of the Council, a new plan has been inaugurated to make our investigating procedure more efficient and more practical.

The Retail Credit Company has been engaged to make additional investigations of applicants seeking aid from the Benevolence Fund when the Committee is in doubt as to the status of the applicants.

The same Company also will be used for re-investigation of beneficiaries when deemed necessary. This service is in addition to standard procedure which has prevailed.

All necessary precautions are being taken to see that the Benevolence Fund is used as originally intended — to give assistance to those who are worthy and in need.

I move that this become part of the report. (Motion seconded by Dr. Edwin A. Lukaszewski, Chicago, and carried).

THE PRESIDENT: This supplementary report will be referred to the Reference Committee on Reports of Standing Committees.

MEDICAL TESTIMONY

To the Members of the House of Delegates:

The Committee on Medical Testimony has had rather limited activity the past year. A few problems came up earlier in the year which were settled by Dr. Hawkinson. A meeting was planned sometime ago at which time Dr. Hawkinson contemplated reporting on his activities and bringing out a plan to further the so-called "Minnesota Plan" which this Committee has attempted to utilize from time to time.

The function of the Committee is to carefully consider any complaints against any of our members who inadvertantly or otherwise gave testimony in the courts which may defeat the means of justice. An occasional professional testifier or an occasional doctor, who has been careless in the statements he has made on the witness stand, has had his testimony reviewed and in the few cases that have come before the Committee or its Chairman apparently a definite amount of good has been accomplished. It tends to make for closer relationship between the medical profession and the legal profession and is a worthwhile plan. However, this work is being done almost entirely by Dr. Hawkinson, our Chairman, and his serious illness of about three months ago has made it impossible for him to carry on. The Committee members, therefore, submit this very incomplete report calling attention to the fact that the Commitee has useful potentialities, but that an active and interested chairman will have to carry on for the coming year providing that is the wish of the House of Delegates.

Respectfully submitted,
E. P. Coleman, M. D.,
Committee on Medical Testimony.

GRIEVANCE

To the Members of the House of Delegates:

There have been four cases referred directly to the Grievance Committee and all were returned to the these cases were being referred direct to the State Grivance Committee and all were returned to the county Society from which they originated without action as there was no authority to act until they had been cleared through the local medical society.

One of the cases from Lake County was reviewed by the County Society and reported to us that a satisfactory solution had been obtained and the charges were cleared.

In a state with over ten thousand doctors in daily practice we feel that this is a very good record and hope it may continue as such.

Harry M. Hedge, M. D.,
Chairman.
*T. G. Knappenberger, M. D.,
Edward Baker, M. D.
Edward H. Weld, M. D.
Percy F. Hopkins, M. D.
C. Paul White, M. D.
Grievance Committee.

---

* *Deceased.*

Reports of Council Committees
Report of Editorial Board and Journal Committee

To the Members of the House of Delegates:

The House of Delegates at its meeting in 1954 suggested more frequent meetings of these two groups which meet jointly. It was hoped that meetings could be held every three months. Unfortunately this was not feasible. Meetings were held in August and December. Partially as a result of these meetings the cover page and the type of the Journal have been changed.

It is hoped that the members of the Society will find the changes to their liking.

James H. Hutton, M. D.
Chairman, Editorial Board.
J. J. Moore, M. D.
Jacob E. Reisch, M. D.
John R. Wolff, M. D.
Edwin M. Miller, M. D.
Frederick H. Falls, M. D.
Raymond W. McNealy, M. D.
Edward F. Webb, M. D.
Arkell M. Vaughn, M. D.
Edwin F. Hirsch, M. D.
Kellogg Speed, M. D.
Harry M. Hedge, M. D.,
Chairman, Journal Committee.
Joseph T. O'Neill, M. D.
Albert Vander Kloot, M. D.
John Lester Reichert, M. D.
Paul P. Youngberg, M. D.
R. C. Oldfield, M. D.

Editors, Illinois Medical Journal

To the Members of The House of Delegates:

Your Editors continue to publish the Illinois Medical Journal under the directions of the State Society Council. We have attempted to serve the interests of the Society and its members. As guardians of the standards of this Journal, we have tried to uphold its traditions in the presentation of worthwhile articles submitted by members from all parts of the state.

We realize that the editorial staff has made errors in its decisions, yet no one is infallible and someone must take the initiative, right or wrong. There are many problems associated with selecting material for publication, and it is our earnest desire to give the readers what they want. Although our Society is composed of physicians with common interests, the editors attempt to satisfy specialists, professors, rural physicians, young and old, and urban family physicians as well.

A number of changes have been made during recent months. We have a new cover and are using paper of a better quality. Some of our type is new and the style of heads, or titles, has been improved. We have incorporated touches of color and have had atmosphere cuts made, for use on different pages. We have also tried to make the style of the Journal more uniform. The captions and the illustrations are more distinctive and are designed to catch the eye.

Our continued efforts to encourage shorter articles are beginning to bear fruit. This permits us to publish more articles in each issue and more physicians are represented. Moreover when an author tightens up his copy and sticks to his main theme, the article becomes more readable. We welcome illustrations because they are informative and help to break the monotony of the printed page. However, we occasionally receive a paper with too many illustrations, and when we call this fact to the attention of the author he generously selects those of greatest value with little or no duplication which otherwise would be evident.

We hope that many of our readers have found the Journal of sufficient interest to read at home in the evening. We know that some physicians prefer to obtain their medical information in this way rather than to sit in a smoke-filled room listening to a lecture and looking at slides projected on a screen.

Excerpts from many leading medical journals are scattered throughout our publication to bring to our readers new ideas and acquaint the busy physician with the work being done by colleagues elsewhere. No abstracts from the Journal of the American Medical Association are used because our members receive this journal each week. We welcome items for the section entitled "News of the State" so send reports of your meetings, actions of unusual interest which are taken, and if a member of your Society is elected mayor, legislator, or receives some other signal honor, we should inform physicians elsewhere of these occurrences.

Our editorials have been diversified. Some concerned current problems in medicine from the scientific standpoint; others were provocative or critical of the abuse of privileges or of outside interests that endanger our professional freedom. We welcome guest editorials on subjects of general or popular interest.

During the past fiscal year we have published a total of 104 original articles. Twenty-three of these were case reports. We have published 10 or more articles in six issues during the year. You will recall that we must have a preliminary program for the coming annual meeting in one issue, and the official program in another each year. Then we must publish the transactions of the House of Delegates in the July and August issues. During the past two years these have been published in abstract, and even this arrangement naturally reduces the number of scientific articles we can publish in these four issues of the Journal.

We have had a total of 78 editorials in the 12 months constituting our fiscal year, from May to April. Of this number, 20 have been scientific editorials, while the remainder were of a socio-economic nature, or editorials commenting on some unusual events, meetings, honors to members, etc. This is a marked increase over the number of papers and case reports published during the preceding year, or during any previous year in the history of the Illinois Medical Journal.

During recent months we have received a number of complimentary letters relative to the improvements in the Journal made during the past year. Some of these came from readers in several states outside of Illinois. We have also received a few criticisms which were quite interesting. These have been relative to some abstracts published from articles in other journals. It is rather difficult to look over a large amount of current medical literature and select the articles for the abstracts which we believe will be of greatest interest to our readers.

We occasionally review the abstracts before publishing them, and remove a few which we intended to send to the printers. It is quite possible that a few others have been approved and printed which may not appeal to some readers. However, we are always glad to receive criticisms as well as bouquets, and it is a pleasure to know that some readers do look over the Journal rather critically.

Once more we desire to pay our respects to our business manager, Mr. L. E. Malley, who has done a fine job in this position over a period of 14 years. Many of the changes in format, paper, type and headings were instituted at his request. Your editors and Mr. Malley get together one day of each week to discuss many problems which are constantly arising, and check our own publication with the many others which come to the office as exchange copies.

Your Editors would like comments from the House of Delegates on the Illinois Medical Journal, and your recommendations for changes or improvements will be greatly appreciated.

Respectfully submitted,
Harold M. Camp, M. D.
Theodore R. Van Dellen, M. D.
Editors.

Report of Delegates to AMA

To the Members of the House of Delegates:

The delegates of the Illinois State Medical Society to the American Medical Association met with the House of Delegates in San Francisco in June as well as in Miami in December, 1954. Herewith is presented a brief report of the principal transactions of the House:

President McCormick in his address pleaded for reconsideration of the action taken by the House of Delegates in December, 1953, approving a new code for physician-hospital relations and at the same time stipulating that this new code should not supersede any previous actions of the House. In his opinion, the latter stipulation confused negotiations between the American Medical Association and the American Hospital Association. As a result of the report of the Reference Committee, this recommendation was referred to the Board of Trustees for further consideration. The same recommendation was made by the Reference Committee in regard to Dr. McCormick's suggestion that the "profession should consider the use of average fee lists, or fee schedules, that should prevail on an area or regional basis."

Testimony before the Reference Committee disclosed that programs similar to the one advocated by Dr. McCormick already were in existence in certain areas.

A resolution having to do with the professional and administrative audit of hospitals, particularly with reference to the accreditation of small hospitals, was also considered. It was pointed out by the Reference Committee that a committee on the problems of the small hospitals was already in existence, appointed to study this problem.

Resolutions having to do with the treatment of veterans with service-connected and non-service-connected disabilities, caused readoption of the stand previously taken by the House of Delegates in this regard.

A report was made by a committee appointed by the Board of Trustees to consider the subject of evaluation of foreign medical schools. This committee recommended that the problem be referred back to the Council on Medical Education and Hospitals for continued general study, that the American Medical Association promote the formation of a commission to be known as the "Joint Commission on Evaluation of Foreign Medical Graduates," that an agency be used to determine by examination the professional fitness of the applicants, and that a method of screening applicants be formulated.

Since the question of states' rights is involved in this matter, the committee stated that it must be clearly understood that the only duty of the commission was to determine the general fitness of applicants, the states being given the opportunity of utilizing the results of this screening, if they so desire.

The Council on Medical Education and Hospitals was to report its progress to the Trustees at subsequent meetings.

This report was adopted.

Further reports were made regarding the policy of the American Medical Association in regard to the dependents of service personnel, and further action will probably be reported in the summary of the December meeting in Miami.

A resolution providing for representation of Non-University-Affiliated Hospitals on The Council on Medical Education and Hospitals was not adopted, since it was felt unwise to encumber the Board of Trustees or House of Delegates with specific limitations in considering nominations and elections to the Council.

A report from the Council on Medical Service recommended that the seal of acceptance program be discontinued because the objectives for which such seal was primarily designed had now been achieved and there is increasing difficulty in conducting the seal program.

This recommendation was adopted by the House.

Miami Interim Session

At the Miami meeting the following actions were taken:

1. The House of Delegates adopted by standing vote a resolution in regard to the death of Dr. Fred H. Muller.

2. The Board of Trustees announced that their donation to the American Medical Educational Fund would be limited to $100,000 instead of $500,000 given every other year.

3. In the report of the Reference Committee the pattern of the procedure of the Illinois State Medical Society in laying aside a certain amount of each individual's dues was highly recommended for other states to follow.

4. In regard to the doctor's draft law, it is reasonable to believe at this time that the Department of Defense will not recommend a continuation or renewal of the doctors' draft law when it expires in June. This will provide for a minimum of medical men in the Armed Forces in 1957, but if they get by that year they will be all right. They aim to have 3.3 doctors per 1,000 troops.

5. The American Osteopathic Association agreed last fall to consider the sitting in on a joint committee from the American Medical Association to allow the on-campus inspection of their schools. Even though that provision was adopted, since that time one school has subsequently dropped out and now five of the six have agreed to the inspection. Any action by the House of Delegates as to whether osteopaths are a cult or are entitled to privileges of medical graduates was held in abeyance.

6. A committee of 13 was appointed by the Board of Trustees to make a study of Medical Service Plans, probably to report back in one year. This is made up of men from all over the United States who are interested in health care plans or medical service plans, and included in the committee is one insurance man.

7. A resolution from Pennsylvania pertaining to the Joint Accreditation Commission and providing for the inclusion of members of the American Academy of General Practice was not adopted.

8. A resolution from Indiana about the joint report of the American Medical Association and the American Hospital Association dated 1951-53, recommending that this report serve as a basis of consideration, was adopted.

9. There was again a resolution in regard to hospitals providing certain services which are classified as professional in the minds of organized medicine, and again the American Medical Association saw fit to reiterate its position in this regard.

10. Colorado and Mississippi introduced a joint resolution which was adopted. This provided for appointment of a committee by the Board of Trustees from county and state societies throughout the country which had had experience with Grievance Committees. This committee is to set up certain recommendations and standards to govern other grievance committees that are not functioning properly or not yet in existence.

11. A resolution from Michigan was adopted about future administrative expansion of facilities of the American Medical Association, particularly pertaining to the Board of Trustees, probably due to the fact that the volume of work thrown on them is so tremendous that it is impossible for them as individuals or as a group to familiarize themselves with much of the details. That is reflected at times when reports on policy are laid down which have occasionally been retracted or changed or have not been adopted. This is an effort to take some of the load off the Board.

12. The Committee on Internships has been very active. There was previously the provision that a hospital would lose its qualification at a suitable institution for intern training if it failed in two successive years to obtain two-thirds of the required number of interns. Apparently that figure is not a realistic one, and a new figure is to be established so that the unhappy situation that now exists can be remedied. The report of this Committee was referred to the Committee on Medical Education and Hospitals, and no action was taken on it.

13. A resolution was adopted which provided for the Joint Commission on Accreditation to send to the chief of staff, the president of the Board of Trustees and the hospital administrator a copy of the findings after a hospital had been inspected.

14. A resolution regarding the policy on the practice of medicine by tax supported medical school was referred to the Council on Medical Service for further consideration and recommendation.

15. The Commander of the American Legion expressed the opinion that there is no reason why the American Medical Association and the American Legion cannot come to an agreement as they have the same objectives.

16. Oveta Culp Hobby appeared before the House and made a long speech. She informed us that another bill on reinsurance was being presented to the next Congress.

17. The House saw fit to adopt a report of the Council on Medical Service about simplification of insurance forms. Work is being done on this.

18. Support was requested for a World Medical Association as opposed to the World Health Organization which is a United Nations project.

19. The care of dependents of military personnel was discussed as well as Civil Service employees. These groups are to be provided with insurance contracts which will care for them and their dependents. It is contemplated that the government will contribute something towards this plan, and that much work is to be done in working out all the details.

Respectfully submitted,

PERCY E. HOPKINS, M. D.,
Chairman, Illinois Delegation.
WALTER C. BORNEMEIER, M. D.
WARREN W. FUREY, M. D.
CHARLES H. PHIFER, M. D.
H. KENNETH SCATLIFF, M. D.
BERNARD J. KLEIN, M. D.
BURTIS E. MONTGOMERY, M. D.
J. M. PFEIFFENBERGER, M. D.
HARLAN ENGLISH, M. D.
EVERETT P. COLEMAN, M. D.
Delegates to American Medical Association.

ADVISORY TO I. P. A. C.

TO THE MEMBERS OF THE HOUSE OF DELEGATES:

The problems confronting the Medical Advisory Committee and the Illinois Public Aid Commission continue to increase. There is pressure on the one hand from the profession to broaden the scope of medical care to these people, and from the Commission on the other to conserve funds since there is a definite limit to the amount of tax money available.

The Committee has received numerous protests and criticisms with respect to the limitations imposed in the care of these Public Aid patients.

The greatest problem at present appears to be the allowance for dispensed drugs. You will recall that last year a definite proposal was made to the Commission which was turned down due to lack of funds.

Again, this year, the Advisory Committee has recommended to the Commission that a single standard be adopted for the payment of drugs regardless of the source. To work out, in conjunction with the Drug Committee, and put into effect such a procedure will involve a tremendous amount of effort and bring into the picture many more difficult problems.

Another proposal made to the Commission was to increase the number of home, office and hospital visits in an acute illness from 6 to 10 in a 30 day period. This would simplify the procedures in the treatment of certain types of acute conditions, and satisfy some of the criticism received by the Committee.

Another complaint which is very prevalent is, that the case workers do not explain to the recipients that the amount of medical care they can receive is limited to essential medical care only. In some instances they have assumed the prerogative of telling the patient they should be in the hospital, whereas that decision is a medical one to be determined only by the physician.

In order to combat the above, the Medical Advisory Committee has recommended to the Commission that County Departments give specific instructions to case workers with respect to the limitations on medical care, and have them relay the information to the recipient in such a manner that these limitations will be understood.

The State Medical Advisory Committee and the Illinois Public Aid Commission have now completed 12 years of cooperative effort toward the objective of providing adequate, essential, and economical medical care to the public assistance recipients.

The State Committee has assumed the responsibility for assuring that the Commission's Medical Care program would be conducted according to accepted ethics and standards of the medical profession. The Committee has also taken responsibility in helping the Commission to conserve resources.

It has been the duty of the State Medical Advisory Committee to help the Commission control expenditures by recommending quantity and cost standards and seeing to it that nonessential diagnostic and treatment services, unnecessary hospitalization, and long unnecessary hospital stays are avoided.

The State Committee has also had the continuing responsibility for reviewing reports of services given by physicians in individual cases, where there is question of abuse, in the interest of preventing excessive care and excessive charges. It is advised that uncooperative physicians or those that overcharge for services, be excluded from participation in the program after a fair hearing.

The State Medical Advisory Committee has always made a sincere effort to establish and maintain close relations with County Medical Advisory Committees. It has always been ready to review problems referred by local Advisory Committees and has always supported and helped the local committees in dealing with problem situations.

Closer relationships have been accomplished by having chairmen and members of County Medical Advisory Committees attend meetings of the State Committee. Twenty-two chairmen and members of local County Medical Advisory Committees have attended and participated in the regular meetings the State Medical Advisory Committee has held in the past year.

In order to have a better overall understanding of the problems concerning the medical care program of the Illinois Public Aid Commission, it is essential to understand the method of financing such a program.

This program is entirely supported by tax money. The Commission, on advice from the Governor and the Budgetary Committee of the Legislature, submits a budget which proposes to finance the entire program for one biennium. The last biennium there was an overall deficiency of about $9,000,000. This was made up by the Legislature with a deficiency appropriation.

A total of $300,000,000 was asked for to cover the last biennium. The Legislature reduced this to approximately $276,000,000. It was on the basis of this reduced budget that the recommendations of the Medical Advisory Committee were not accepted. In fact, the Commission ruled that there would be no increases for medical expenditures. This ruling froze the hospital rates at the 1953 level as well as not permitting an increase in allowances for drugs.

In spite of careful planning and supervision the cost of medical care has doubled since 1949. The following statistics should be of interest. (See table on page 85).

It can readily be seen that the medical profession in Illinois should cooperate to the fullest extent, by rendering only essential care to these recipients as economically as possible. To do this it is necessary not to give excessive care; to use less expensive drugs where possible; to reduce to a minimum unnecessary and prolonged hospitalization; use only the necessary laboratory and diagnostic procedures and finally to come up with a solution to the very costly nursing home problem, all of which is charged to medical care.

It is regrettable to say, but nevertheless true, that there has been a tremendous decline in the moral responsibility of families in caring for their aged and incapacitated in the past two decades. This one factor alone has caused a large increase in the population of nursing homes in the past few years.

As an indication of the thinking of other groups in the profession, following is quoted an editorial, by Dr. Harold Swanberg, from the Mississippi Valley Medical Journal, November, 1954.

MEDICAL EXPENDITURES 1949-1954

Year	Total	O.A.A	ADC	B.A	D.A
		Amount Paid			
1949	$12,836,614.07	$11,364,425.92	$1,112,249.03	$359,939.12	NA
1950	13,272,170.01	11,875,719.01	1,039,294.91	357,156.09	NA
1951	15,053,844.47	13,396,512.84	1,009,813.50	401,639.43	$ 245,878.70
1953	24,054,628.30	19,580,021.37	2,045,952.22	528,866.71	1,899,788.00
1954	25,339,445.31	20,320,870.43	2,090,807.36	546,383.71	2,381,383.81
	(50% increase)				
		Average Monthly Number of Patients			
1949	45,044	37,333	6,567	1,144	NA
1950	43,150	35,812	6,233	1,105	NA
1951	43,545	35,977	6,048	1,071	449
1953	47,695	38,678	5,521	1,138	2,358
1954	47,284	37,743	5,596	1,136	2,809
	(5% increase)				

Exhaustive Clinical Laboratory and X-Ray Examinations

"There is a tendency, especially by young physicians and particularly by physicians graduated from foreign medical schools, to request multiple clinical and laboratory x-ray examinations in connection with their patients. Too much reliance is placed on the laboratory side of medicine rather than on the history and physical diagnosis, especially in minor illnesses. These multiple clinical laboratory and x-ray studies greatly add to the cost of medical care. There is, of course, no denial that multiple examinations are necessary and proper in many patients. The almost routine practice of ordering a lot of laboratory and x-ray studies on nearly every patient seen, especially if such examinations are to be paid for by public funds, is one to which we object. There is a special temptation to do these multiple studies if the physician has his own clinical laboratory and x-ray apparatus and if the fees are to be paid from public funds. With our aging population and with the ever increasing number of persons who are obtaining old age assistance benefits from the State, the medical care of such persons becomes a serious financial problem from a tax standpoint. Certainly these unfortunate people must have good medical care but the medical profession can cooperate to see that it is rendered at a minimum cost to help relieve the tax load. While we are not prepared at this time to suggest a remedy for excessive clinical laboratory studies we believe that if the proper county and state public commissions would pass rulings as shown below, the x-ray situation would be materially remedied:

"Fees for x-ray service shall not be allowed unless rendered in a registered hospital or by a physician who is a member in good standing in a recognized national radiological society or is a diplomate of a specialty board. An exception to this ruling shall be in the case of x-ray examinations of fractures or dislocations or suspected fractures or dislocations when rendered by physicians more than 15 miles from the above services."

"It is sincerely urged that every physician in Illinois cooperate to the fullest extent with your State Medical Society, in giving these public aid recipients good, essential medical care as economically as possible, consistent with a tax supported program."

Your committee will always welcome any constructive thinking or suggestions with reference to the problems of this program. Any physician desiring to attend a meeting of the State Medical Advisory Committee may do so by letting your wishes be known, and an invitation will be extended.

The following table showing the cost of medical care from December, 1953 through July, 1954 should be of considerable interest. You will note that there has been a gradual increase in the cost of medical care, totaling about $100,000 per month in July, 1954. This projected would mean an increase of about $1,200,000 for the year, with the patient load remaining about the same.

Illinois Public Aid Commission

OBLIGATIONS[a]/FOR MEDICAL CARE BY TYPE OF SERVICE, ALL PROGRAMS
DECEMBER 1953 - JULY 1954
TOTAL STATE

Type of Service	December 1953	January	February	March	April	May	June	July
				AMOUNT				
ALL SERVICES	$2,007,363	$2,075,626	$2,077,991	$2,219,579	$2,173,243	$2,201,221	$2,120,248	$2,107,854
Nursing Home Care	1,047,318	1,059,779	1,084,301	1,086,922	1,092,904	1,091,186	1,096,618	1,094,158
Medical Care	960,045	1,015,847	993,690	1,132,657	1,080,339	1,110,035	1,023,630	1,013,696
Physicians' Services	208,964	221,991	224,173	240,935	228,288	227,346	217,968	212,726
Drugs								
Dispensed	54,285	57,364	55,969	62,205	59,398	58,919	58,060	56,306
Prescribed	104,941	111,291	110,659	127,896	122,947	122,490	123,962	122,833
Hospital Care	520,411	549,923	518,528	604,004	579,573	611,540	535,730	536,246
Other	71,444	75,278	84,361	97,617	90,133	89,740	87,910	85,585
				NUMBER OF PATIENTS				
ALL SERVICES[b]/	-	-	-	-	-	-	-	-
Nursing Home Care	10,439	10,756	10,815	10,825	10,904	10,933	10,959	10,961
Medical Care[b]/	-	-	-	-	-	-	-	-
Physicians' Services	34,539	36,235	36,767	38,859	37,529	36,414	35,834	35,324
Drugs								
Dispensed	20,969	21,789	21,768	22,903	22,120	21,490	20,967	20,796
Prescribed	19,340	20,470	20,614	22,501	21,804	21,309	21,018	20,934
Hospital Care	3,673	3,808	3,675	4,079	4,004	4,018	3,813	3,639
Other	5,527	6,833	6,302	7,035	6,765	6,674	6,485	6,419

a/Based on medical payments reported through January 1955.
b/Unduplicated count of patients not available.

Research and Statistics Section

It is the duty of every physician, therefore, to scrutinize his practice very carefully and help to eliminate excessive care, excessive and expensive drugs, and to cooperate to the fullest extent with your State Medical Society in making this program function within our own jurisdiction, rather than seeing it slip more completely into a totally Socialistic program, over which we have no control.

Respectfully submitted,

B. E. Montgomery, M. D.,
Chairman.
Edwin S. Hamilton, M. D.
Julius H. Hess, M. D.
Harlan English, M. D.
Charles P. Blair, M. D.
Theodore R. Van Dellen, M. D.
Joseph W. Compton, M. D.
Charles Lesage, M. D.
Ex-Officio:
Arkell M. Vaughn, M. D.
President.
Joseph T. O'Neill, M. D.
Chairman of the Council.
Harold M. Camp, M. D.
Secretary.

Advisory Committee to Illinois Public Aid Commission.

Sub-Committee on Ophthalmology of the Advisory Committee to the IPAC.

To the Members of the House of Delegates:

The annual meeting of the Sub-Committee on Ophthalmology was held on February 12, 1955, at the Drake Hotel in Chicago. Present at this meeting were all the members of the Sub-Committee, namely: Watson Gailey, M. D.; Leo P. A. Sweeney, M. D.; Max Hirschfelder, M. D.; and Derrick Vail, M. D.

A number of minor subjects were discussed and were found to be solved by the Sub-Committee. We were very fortunate in having with us, by invitation, James Robert Fitzgerald, M. D., who is Supervising Ophthalmologist with the Illinois Public Aid Commission. This, of course, expedited the solving of a number of problems by our Sub-Committee.

Respectfully submitted,

Watson Gailey, M. D.
Chairman.
Leo P. A. Sweeney, M. D.
Max Hirschfelder, M. D.
Derrick Vail, M. D.
Sub-Committee on Ophthalmology.

DR. B. E. MONTGOMERY: I have a supplementary report. To the House of Delegates:

The question of dispensed drugs was purposely omitted from the report of this Committee as published in the Handbook, the reason being that the Committee had made certain recommendations to the Commission which had not been passed upon. The Committee has frequently discussed this problem and made recommendations to the Commission. On one occasion members of the Committee appeared personally before a sub-committee of the Commission with recommendations on drugs.

The Commission has always held that due to budgetary restrictions by the Legislature, no increases in allowances for dispensed drugs could be made.

At the February 1955 meeting of the Advisory Committee a resolution was adopted and sent to the Medical Department of the Commission. This resolution was in substance as follows:

> "Be it resolved, that the Commission is urged to discontinue the dual system of payment for drugs as it now exists, and to establish and put into effect one system of drug charges for all vendors under this program."

Within a short time after presenting this resolution to the Medical Department, a letter was received from this Department requesting that this Committee secure a ruling or interpretation from the Judicial Council of the A.M.A. of Section 8, Chapter I of the Code of Medical Ethics which reads as follows:

"It is unethical for a physician to participate in the ownership of a drugstore in his medical practice area unless adequate drugstore facilities are otherwise unavailable. This inadequacy must be confirmed by his component medical society. The same principle applies to physicians who dispense drugs or appliances. In both instances, the practice is unethical if secrecy and coercion are employed or if financial interest is placed above the quality of medical care. On the other hand, sometimes it may be advisable and even necessary for physicians to provide certain appliances or remedies without profit which patients cannot procure from other sources."

Your Chairman immediately addressed a letter to the Judicial Council requesting an opinion on the above Section 8. The Council does not meet until June 1st, hence no ruling is available.

In view of the above, the Medical Advisory Committee felt that a substitute resolution should be formulated and sent to the Commission which would allow an increase in the allowance for drugs sufficient to cover cost of handling, breakage, overhead, bottles, out dating, etc. The following resolution was therefore adopted by the medical Advisory Committee and the Council of the Illinois State Medical Society.

> "Resolved, that the State Medical Advisory Committee urges that the service charge for dispensed drugs be increased from 5% to 20% over the initial cost of drugs to the physician."

At the meeting of May 6th the Illinois Public Aid Commission agreed to the increase and effective June 1st will pay the dispensing Doctor 20% above the wholesale cost of drugs.

The results of the questionnaire mailed to members of the House of Delegates will be compiled and the results mailed to the Secretary of each county medical society.

Respectfully submitted,

(Signed) B. E. MONTGOMERY, M.D.
Chairman, Medical Advisory Committee
of the Illinois State Medical Society
to the Illinois Public Aid Commission.

THE PRESIDENT: This supplementary report will be referred to Committee "A", Dr. Warren Furey, Chairman.

ADVISORY TO AMERICAN LEGION

To the Members of The House of Delegates:

Your Committee continued to study the problems which have arisen between the American Medical Association and the American Legion over the proper disposition of medical care of non-service connected Veterans.

One meeting was held this year in March, in Chicago, which was attended by all committee members.

Plans had been made to hold the first meeting early in the year. Lester Benston, Rehabilitation Director, the American Legion, Department of Illinois, was contacted for a possible date and for names of proper representatives both from the American Legion and from the Veterans' Administration. The meeting did not materialize due to the fact that the national committees of the A.M.A. and the American Legion were soon to meet. It was thought best to defer the State meeting and await the outcome of the National meeting for instructions. The National Committee is composed of three representatives of the A.M.A. and three men from The

American Legion appointed by the National Commander. This group has now met but so far no specific report of their deliberations has been released and more probably will not be forthcoming until more discussions have been taken by them.

In the meantime, State and County meetings will go forward to disseminate information on these two respective levels. Following this procedure, your Committee was called together in March when an interesting and informative discussion took place, but no specific action resulted.

Dr. Bornemeier, who represented our State Committee at the Edgewater Beach Hotel, Chicago, on April 19th at a meeting called by the A.M.A., reported on the meeting which was one of a series of similar conferences that the A.M.A. is holding throughout the country. Among the things reported were these: that of Home Care for Veterans; that the relationship between the American Legion groups and Medical Societies should always be on a friendly basis; that when a future Speakers' Bureau is created, it should only name those to speak who are well-informed and able to speak on any veteran subject; that a national committee would check with the Veterans' Administration to clear up the controversy on bed capacity and treatment. The prevailing thought expressed was that the greatest number of complaints was against the method rather than the established policy of the Veterans' Administration.

At the March meeting, Dr. Mellin spoke on the care of Neuropsychiatric and other non-service connected cases. He further stated that there would be more meetings held on the national level with the six man committee (of which he is a member) and he expressed the thought that such meetings would result in bringing the two organizations closer together.

We were happy to have as our guests other doctors who were interested in the problems we were discussing.

The members of the committee are all intensely interested and have fine knowledge of the problems before them. There is also an understanding that it is only by patient, mutual discussions on both sides, and an unbiased study of the over-all picture that a satisfactory disposition of non-service veterans' care can ever be realized. This is the ultimate hope of your Committee.

Respectfully submitted,
NORMAN L. SHEEHE, M. D.
Chairman.
W. C. BORNEMEIER, M. D.
L. ROBERT MELLIN, M. D.
JACOB E. REISCH, M. D.
JAMES A. WEATHERLY, M. D.
Advisory Committee to the American Legion, Department of Illinois.

ADVISORY TO VETERANS ADMINISTRATION

TO THE MEMBERS OF THE HOUSE OF DELEGATES:

Since the reorganization of the Veterans Administration, initiated July 1, 1953, the Department of Medicine and Surgery became an autonomous unit, headed by the chief medical director, who is responsible only to the Administrator of Veterans' affairs.

The Medical Division of the Regional office, which is the agency with which we have contact, became the out-patient service of the Veteran Administration's new West Side Hospital at 820 South Damen Avenue, Chicago 12.

Lee H. Schlesinger, M. D., is the manager of the hospital, and is in over-all charge of the service. It is to Dr. Schlesinger that requests for service for out-patients should be directed.

The report of the medical services rendered eligible veterans in Illinois by participating physicians under contract of the Illinois State Medical Society with the Veterans Administration is presented herewith.

The Veterans Administration authorized 17,335 treatments or examinations to 8,973 veterans at a cost of $85,855.00 to participating physicians under contract with the Illinois State Medical Society during the calendar year 1954. The staff of the Veterans Administration rendered comparable service of 100,818 visits to 54,719 veterans respectively in this period.

Forty-four veterans received 263 visits from local community nursing service during 1954 and there was a total of $1,007,888.00 authorized for hospitalization in other than Veterans Administration hospitals during this same period. Ninety per cent of this represents hospitalization for neuro-psychiatric patients.

The figures enumerated above include service rendered to 1,281 Spanish American War veterans on a fee basis and 1,519 by staff. The fact that these veterans have by law been declared service connected for all disabilities for outpatient treatment purposes and the fact that their infirmities and age necessitates authorizing practically 50% of this service on a fee basis is obvious. Of the 392,000 veterans participating in the Spanish American War there were 11,000 living as of April 30, 1954 throughout the United States.

It is anticipated that as the number of years since World War II increase there will be a progressive decrease in the number of service connected disabilities of these veterans requiring treatment. These disabilities in many instances may become either static or in remission. At the present time this does not hold true for Korean veterans of which there are about one-sixth the number of World War II veterans.

Practically no problems can be recalled which have arisen during the past year in this program. One suggestion is made which will aid us considerably is that in submitting prescriptions to our Pharmacy the official or chemical name be used rather than the trade name. The reason for this is that the Veterans Administration may have an over-all contract for the identical medication, and the use of this contract medicine under its official name, when available, will result in a marked over-all savings to the Veterans Administration and the taxpayer.

The cooperation of the Illinois State Medical Society, its participating members in continuing to uphold the high standards of care to the service-connected disabilities of veterans is extremely gratifying to the Veterans Administration.

Drs. Schlesinger and C. H. Ogden, who had charge of the program are to be thanked for their friendly consideration and cooperation in making this contract work out satisfactorily.

Respectfully submitted,
PERCY E. HOPKINS, M. D.
Chairman.
F. LEE STONE, M. D.
Vice-Chairman.
LEO P. A. SWEENEY, M. D.
CARL F. STEINHOFF, M. D.
HAROLD M. CAMP, M. D.
Advisory Committe to the Veterans Administration.

ADVISORY TO UNITED MINE WORKERS

TO THE MEMBERS OF THE HOUSE OF DELEGATES:

During the past year three meetings have been held by your Committee, one at the meeting of the Illinois State Medical Society in Chicago, one in September, 1954, and the third in February, 1955. The enthusiasm with which every proposed measure has been discussed has been a source of great satisfaction to the Chairman and should be very gratifying to the medical profession of the State of Illinois. The relationship between this

Committee and the United Mine Workers of America Welfare and Retirement Fund remains very amicable and the association with the Area Administrator continues to be very cordial. Several members have served on the Committee for a number of years and we have the feeling that a greater understanding of existing problems is enhanced by the experience of these veteran members. In the last two years several new members have been appointed who have proved valuable additions to our group.

The many friends of Dr. Cecil A. Z. Sharp, Area Medical Administrator of the United Mine Workers of America Welfare and Retirement Fund in St. Louis, Missouri, who had known him as a capable and fair administrator, were stunned by his sudden death at the hands of a mentally retarded assasin in June of 1954. Dr. Sharp was the pioneer area administrator in this district and much of the success of the Welfare Fund in this region was due to his untiring efforts to please all concerned, his primary object, of course, being the proper care of the welfare recipients. A resolution of condolence was drafted by the Advisory Committee and sent to the wife and children of Dr. Sharp.

Your Committee was pleased to note the appointment of Dr. George Brother to succeed Dr. Sharp. It has been our pleasure to have known Dr. Brother for some time and his pleasant disposition and courteous cooperative spirit were well known to us. It was therefore no surprise to find that he very capably took up the reins of administration and we are confident that the smoothly functioning character of the United Mine Workers of America Welfare and Retirement Fund will continue as will its cordial relationship with the medical profession.

It has been stressed by the Area Administrator at all our meetings that there is greater need for careful attention on the part of the profession to the prevention of needless and prolonged hospitalization, repeated hospitalization of the same patient throughout the year, many times under different physicians, the occasional tendency to overcharge on surgical operations and the summoning of proper consultation. A survey made by the St. Louis Area Office records from July 1, 1953 to August, 1954, showed a total of 289 patients having been admitted to the hospital four times or more during that period. We are well aware that conditions such as this exist for one of two reasons: the unreasonable demands of the patient who seeks to abuse his Welfare privileges, or the lack of courage on the part of the physician in denying hospitalization to a case obviously not needing it so frequently. The matter of overcharging in surgical fees, while coming up for discussion at strikingly infrequent intervals in the past two years, still crops up occasionally and it is the feeling of the Committee that the method of handling such cases by the Area Administrator has been very satisfactory in the past.

At each one of the Committee's three meetings in the past year the words "accreditation of hospitals" seemed to appear with marked frequency, and undobtedly we will hear more about it in the future. It is the aim of the Welfare Fund to provide the recipients with the best care with the funds available and the general office in Washington has on several occasions expressed the opinion that the most considerate and most skillful treatment would be available to the recipients if all could be cared for in hospitals whose accreditation has been granted. The subject is necessarily controversial because in many areas in our own state, no hospitalization is available in an accredited institution within commuting distance, and to date the Fund has not seemed unreasonable in its attitude of compromise in such cases. It seems pretty definitely understood by your Committee members that in the not too distant future insistence will be upon hospitalization of all recipients in accredited institutions.

If we are able to read between the lines, it is rather manifest that the time is fast approaching when the Welfare Fund will insist on all major surgical procedures being performed by qualified surgeons. The definition of "qualified" rests to a great extent upon the Area Administrator, but in general it is thought to mean a man whose surgical training comprises a sufficient number of years to qualify him for application to take the examination for the American Board of Surgery and/or the American College of Surgeons. The Committee feels, of course, that the Welfare Fund is well within its rights in this matter as it is seeking only the best possible care for its recipients. We feel, however, and we have discussed the matter thoroughly at our meetings, that exceptions must be made in the case of experienced surgeons who are, nevertheless, not qualified in the accepted meaning of the term. The Committee also feels that present day graduates would do well to seek the proper qualifications if they wish to be listed as participating surgeons because this is a modern trend and certainly the scope of the United Mine Workers of America Welfare and Retirement Fund is sufficiently encompassing that it might well set a precedent in this regard. Changes in the coverage of surgical cases favoring the qualified surgeon only are probably marked for early adoption by the Welfare and Retirement Fund.

Another point which deserves consideration is that a survey made by the United Mine Workers Welfare Fund of the admission rate, average length of stay in hospitals and the number of days of stay per 1000 beneficiaries last year compared with Blue Cross and other hospitalization insurance companies, shows the other Funds have smaller percentages in all divisions. If the Blue Cross, the Blue Shield and other per-paid plans complain about the same abuses and the United Mine Workers of America Welfare and Retirement Fund's recipients are showing still higher rates of hospitalization, etc., your Committee is greatly concerned and we feel that the attention of the profession should be called rather seriously to a matter which a little effort and foresight can readily correct. As a profession we should certainly keep our house in order at all times, but particularly at present.

It is a pleasure to report that the problems facing your Committee are fewer and perhaps a trifle less serious each year. On the whole, the Committee has attempted to take a broad view of the controversial subjects and your Chairman can report very definitely that the Area Medical Administrator's Office is highly pleased and very appreciative of the cooperation shown by your Committee.

Your Chairman has been a member (or chairman) of the Committee since its inception and over a period of years a lot of very troublesome subjects have been eliminated by the gracious understanding of both parties concerned and it is our feeling in making this report that the relationship existing between the Welfare and Retirement Fund and the Advisory Committee of the Illinois State Medical Society, while a most important one, has been very cordial, very business-like and that it has served the best interests of the profession.

Respectfully submitted,

W. A. Monaghan, M. D.
Chairman.
B. E. Montgomery, M. D.
W. W. Fullerton, M. D.
A. R. Brandenberger, M. D.
J. A. Mathis, M. D.
Charles Ahlm, M. D.

Advisory Committee to the United Mine Workers of American Welfare and Retirement Fund.

ADVISORY TO SELECTIVE SERVICE

To the Members of the House of Delegates:

During the past year, the Illinois Advisory Committee has been kept very busy reviewing the cases of all physicians within the state. Not only have we reopened and reviewed the cases of all physicians in priorities I, II and III, but we have greatly reduced the number of essential cases within the state.

We have not recommended the essentiality of resident physicians during this past year, which is in accordance with the policy adopted by the National Advisory Committee.

In June of last year, the Advisory Committee again sent a representative to talk to the graduating medical school students in order that they might be informed of their liability for service. One Hundred and Seventy-Four (174) of these graduates were Illinois Selective Service registrants and we requested that they be declared essential during their year of internship. As of 1 April 1955, this committee recommended that they be considered available so their local boards might process them for service prior to the completion of their year of training.

As of this time, we have no information which shows we will be able to recommend essentiality for residencies in the future.

We now have only two (2) priority I registrants declared essential in the private practice of medicine in the state of Illinois—one is practicing in Saybrook and the other in Virginia.

There are two (2) piority II registrants declared essential in the private practice of medicine in the state of Illinois—one is practicing in O'Fallon and the other in Galva.

There are seven (7) priority III registrants declared essential in the private practice of medicine in the state of Illinois and they are practicing at Valmeyer, Industry, Springfield, East St. Louis, Stewardson, Hebron and Chapin. Of this total of seven (7) priority III registrants, four (4) were born in 1915. We have reviewed the cases of all physicians born after 1 January 1915. However, Selective Service has called only priority III physicians born after 1 January 1917.

We have declared very few teachers essential in the past year and at this time have only four (4) priority I and three (3) priority III in this category. The three (3) teachers in priority III who are essential were all born before 1917, so they are not immediately liable for service.

The Advisory Committee contacted the secretaries of all the county medical societies this year, requesting them to advise us of any physicians practicing within their county who are not members of their county and state societies so we might have full information on all physicians practicing within a given county. This data helps us tremendously to determine the full medical facilities available to any given town within the state of Illinois.

As of this time, it is not known whether or not the so called Doctor Draft Law and the Advisory Committee under the Universal Military Training and Service Act as Amended, will be continued for another two years as requested by the President. At such time as further information is made available to us with regard to the continuation of this legislation, it will be furnished to the State Medical Society.

Respectfully submitted,

Carl F. Steinhoff, M. D.
Chairman.
Leo P. A. Sweeney, M. D.
James Majarakis, M. D.
F. Garm Norbury, M. D.
Harold M. Camp, M. D.

Advisory Committee to Selective Service.

ADVISORY TO WOMAN'S AUXILIARY

To the Members of The House of Delegates:

The year just closing seems to have carried on for the Woman's Auxiliary, the same tradition of progress its 27 years of existence have previously shown. The Officers, Directors, Councilors and other responsible workers have shown complete understanding and earnest helpfulness in regard to the problems of medicine which have been called to their attention.

All component county auxiliaries have participated in the various projects with which they have been concerned. Brief mention must be made of their earnest efforts in promoting the sale of the History of Medicine in the State of Illinois. Nurse Recruitment activities, the Benevolence Fund, the Medical Education Fund, the promotion of "Today's Health," all have received their share of attention throughout the year.

One component auxiliary—the Chicago Medical Society Auxiliary—reflected considerable credit on itself and contributed greatly to the outstanding success of the Clinical Conference of the Chicago Medical Society by serving as hostesses—for the first time—to the wives and visitors who helped to swell the 6,000 registration of the Conference.

A difference of opinion arose between one component and the State Auxiliary on interpretation of the By-Laws of their respective auxiliaries. This caused some earnest concern among Advisory Committee members relative to the actual role of the Advisory Committee, and led to a decision as to the Committee's function in service to the Society as well as to the Auxiliary. Through a mutual exchange of ideas it was thought the committee could best serve "standing by" answering questions bearing on public relations, in interpreting to the Auxiliary matters of medical policy and leaving internal operation and method of action to the Auxiliary—unless and until a disservice would occur if mediation were neglected.

Your Chairman would be remiss if he did not acknowledge the splendid cooperation from all committee members, members of the Council, the Chairman of the Council and the helpful consideration of our legal counsel.

It is pleasing to note that our confidence, both as to wives and auxiliary members is in safe hands. Their activities are most helpful to medicine, they present our best facet to the public.

Respectfully submitted,

H. Kenneth Scatliff, M. D.
Chairman.
Warner H. Newcomb, M. D.
H. Close Hesseltine, M. D.
Harold M. Camp, M. D.

Advisory Committee to The Woman's Auxiliary.

Report of Woman's Auxiliary

To the Members of The House of Delegates:

The Woman's Auxiliary to the Illinois State Medical Society has successfully completed its twenty-seventh year of activity with a growth in membership and accomplishment. Our theme, *Leadership in Community Health,* was borrowed from the National Auxiliary, and with this in mind, we have tried to maintain the high ideals of the medical profession.

The following is a report of the highlights of the year:

Benevolence. The Fund has been increased by the addition of four thousand five hundred dollars. This amount was raised through dues of one dollar per member, additional contributions, and the establishment of a number of memorial funds.

Bulletin. All members were urged to subscribe to the Bulletin, the official magazine of the Woman's Auxiliary to the A.M.A.

Illinois Auxiliary News, edited by Mrs. Carl Sibilsky, was printed three times this year through the courtesy of Mr. Web. Johnston, Monmouth, Illinois. In the fall twenty-five hundred copies of the News were sent to various counties throughout the state where some interest in auxiliary organization had been evidenced.

Legislation. Every county legislation chairman has received a copy of the Washington News Letter and This Week in Springfield. The chairmen were urged to report on legislative activity at the monthly auxiliary meeting and keep the membership informed on pending national and state legislation of interest to the medical profession. A School of Instruction for County Presidents was held in Springfield in October. Mr. Joseph Stetler, A.M.A. Legislative Director, spoke on "A Look at the Record" and Mr. Walter Oblinger, Associate Counsel for the Illinois State Medical Society discussed probable medical bills to come before the State Legislature. Many auxiliaries have had outstanding programs on legislation.

Organization. At the present time our membership is approximately two thousand five hundred. There are thirty-six county auxiliaries, one branch in St. Claire County and thirteen branches in Cook County. Two new auxiliaries were added this year—DuPage and Effingham Counties; and two branch auxiliaries in Cook County—Southern Cook County Branch and Douglas Park Branch.

Program. The National program material was sent to all county auxiliaries and emphasis placed on nurse recruitment, legislation, mental health, safety, civil defense, public relations and "A family physician for every physician's family."

Public Relations. Since the doctor's wife is her husband's best public relations agent, she has been urged to assume her role of leadership in health in her community. A survey of the reports sent in by county presidents shows that the individual member has served her community in the following ways:

1. Red Cross (Bloodmobile and Gray Ladies). 2. Cancer. 3. Tuberculosis. 4. Mental Health. 5. School Health Program (worked in the hearing clinics for local schools and vision tests for school children). 6. Community Chest Drive. 7. Girl Scouts and Boy Scouts. 8. Hospitals (sewed for the hospitals and worked with hospital auxiliaries). 9. Crippled Children's Coordinating Centers. 10. 4-H Club Leaders. 11. Safety Council. 12. Diabetic Detection Clinic. 13. Staffed booths during the polio drive. 14. Staffed State Fair Booth for the Illinois State Medical Society.

Today's Health. To date about 50% of our quota of subscriptions to Today's Health have been received. The following counties have secured 100% or more of their quota: Madison, McLean, Warren, Henry, Mercer, Tazewell, and DuPage.

Nurse Recruitment. More emphasis was placed on nurse recruitment than any other public relations project. We have tried to interest high school girls in choosing the nursing profession by establishing Future Nurses' Clubs. The report is not complete but to date approximately four thousand five hundred prospective students have been contacted. Thirty-seven nursing scholarships are available throughout the state from the various county auxiliaries and a number of additional scholarships are being set up and will be available this fall.

Medical History. The Auxiliary was asked by the Illinois State Medical Society to promote the sale of the Medical History of Illinois. During the summer the county presidents, members-at-large, and state board members were notified about this project. 800 order blanks were mailed out by this officer. Dr. Jacob Reisch, Councilor for the Fifth District, spoke to the county presidents at the School of Instruction in Springfield on October 13th. County Auxiliaries were urged to place a copy in their public libraries and hospital libraries.

This officer wishes to thank the advisory committee, Dr. Harold Camp, Dr. Warner H. Newcomb, Dr. H. Close Hesseltine, and Dr. H. Kenneth Scatliff, Chairman, for the advice given to her this past year. All matters of policy and the convention plans were submitted for approval. This officer is also appreciative of the help given to her by Miss Ann Fox, Mr. James Leary and Mrs. Frances Zimmer.

The Woman's Auxiliary is indeed grateful to the Illinois State Medical Society for its financial aid—printing, mimeographing, convention money and the mailing of the Illinois Auxiliary News.

This officer has visited thirty county auxiliaries this year and feels that all of them are trying to serve the purpose for which they were organized. Every state officer and chairman has done her job well and the results are very gratifying.

Respectfully submitted,

Mrs. Albert Kwedar, *President.*

Woman's Auxiliary to the Illinois State Medical Society.

BLOOD BANKS

To the Members of the House of Delegates:

At the October, 1954 meeting, the Council approved sponsorship of a Blood Bank Clearing House for an eleven (11) state area called the North Central District. Furthermore, a loan of six thousand dollars ($6,000) was allocated to finance this undertaking.

In November, 1954, Mr. John Neal drew up the articles of the incorporation under the general not-for-profit-corporation act of the State of Illinois. The first Board of Directors were: Dr. Arkell M. Vaughn, President of the Illinois State Medical Society and Dr. Coy C. Mason, District Representative of the American Association of Blood Banks and Chairman of the Blood Bank Committee of the Illinois State Medical Society. The purpose of the corporation was explained:

A. To establish, maintain and operate a Clearing House among such Blood Banks, either now, or as existing, or hereafter created, as may wish to become affiliated with this Corporation for that purpose; and to supervise or handle any transfers or exchanges of blood or blood products between or among any such blood banks, to the end that maximum utilization may be made of all blood and blood products within the area served.

B. To own, deal with and dispose of real and personal property, and to engage in any and all lawful activities which can or may enhance or further the effective operation of the Corporation as a Blood Bank Clearing House.

In late October and early November approximately 40 letters were sent to Blood Bank Directors and other interested individuals in the 11 state area, inviting them to attend the first Organizational Meeting of the Clearing House, on Friday, November 19, 1954, at the Drake Hotel. The agenda of this meeting was outlined to each participant. The complete minutes of the meeting are filed in Dr. Camp's office in Monmouth. Among those attending this meeting were Dr. Louis Limarzi representing the Council of the State Medical Society and Dr. Gershon Greening, a member of the Blood Bank Committee of the State Medical Society. In essence the meeting accepted the Clearing House program and the participants at the meeting approved the appointment of a five-man committee to draft a set of By-Laws which would guide the operation of the Clearing House.

Dr. Paul Van Pernis, Medical Director of the Winnebago County Medical Society Blood Bank of Rockford, was made Chairman of this Committee. Other members were Dr. Albert Wolf, of the Samuel Deutch Serum Center, Chicago; Dr. Tibor Greenwalt, Medical Director of the Community Blood Bank of Milwaukee,

Wisconsin; Dr. Alvin Matson, Medical Director of the War Memorial Blood Bank in Minneapolis; and Dr. C. S. Culbertson, Medical Director of the South Bend Community Blood Bank.

Your Blood Bank Committee is most grateful for the leadership given to the By-Laws by Dr. Van Pernis and for many hours of deliberation by Committee members.

On January 26, 1955, in the Old Chicago Room at the Sherman Hotel, a second Organizational Meeting was held. The By-Laws of the North Central District Clearing House were approved and they are on file in Dr. Camp's office.

A few short descriptions of the By-Laws are recorded here to illustrate the scope of operation and the composition of the Board of Directors:

Chapter I—Section 1. "Business to be conducted without profit. This Corporation shall conduct and carry on its business without profit to itself or to its members. No member of this Corporation shall by reason of membership herein be, or become entitled at any time to receive, any assets, property, income or earnings from the Corporation, or to profit therefrom in any manner etc."

Chapter II—Section 1—Membership: "The members of this Corporation shall consist of: 1. The participating Blood Banks, 2. The Cooperating Blood Banks. *The participating Blood Banks* shall be those independently operating Blood Banks and Red Cross Regional Blood Centers licensed by the National Institutes of Health.

The cooperating Blood Banks are those Blood Banks which are not licensed by the National Institutes of Health.

The participating Blood Banks shall pay an annual fee for membership as designated by the Board of Directors of the North Central District Clearing House and the cooperating Blood Banks shall pay a lesser fee as designated by the Board of Directors of the North Central District Clearing House.

Comment: It has been suggested that the annual fee for the *participating* blood banks probably will be $50 and the annual fee for the *cooperating* blood banks will be from $5 to $10.

The *original participating blood banks* shall be independently operating blood banks and Red Cross Regional Blood Centers designated by the Committee for Preparation of By-Laws, for the North Central District Blood Bank Clearing House.

Chapter V—Section 1—Corporate Powers vested in Board of Directors—The first Directors, numbering eleven (11) persons, each of whom shall represent one state in the North Central District shall be appointed and designated by the Committee for the Preparation of By-Laws of the N. C. D. C. H. and shall hold office until the Annual State Meetings in 1955. At the 1955 regular Annual State Meetings, Directors shall be elected to serve as follows:

For a term of one year, three directors, one from each of the states of Illinois, Iowa and Indiana; four directors, one from each of the states of Kansas, Michigan, Minnesota and Missouri, shall be elected to serve for a term of two years; and four directors, one from each of the states of Nebraska, North Dakota, South Dakota and Wisconsin, shall be elected to serve for a term of three years; and then after directors shall be elected, one from each state in which the directors term expires at the State's Annual Meeting, to hold office for terms of three years each, and until their successors are elected or appointed, or until removed as provided by these By-Laws. In addition, the Midwest Area Red Cross will be invited to appoint one voting representative to the Board of Directors of the Clearing House. Each State Medical Society will be invited to send a non-voting ex-officio member to the Board of Directors of the Clearing House. One voting director to represent the Hospital Associations in the eleven states shall be selected by the Hospital Association to serve for a term of one year.

It is encouraging to note that Dr. Barnes, Regional Director of the Red Cross out of St. Louis, Missouri, has agreed to serve on the Board and attended the first meeting, of the Board.

The first meeting of the Board of Directors was held on February 23, 1955, in the Conference Room of the Chicago Office of the Illinois State Medical Society, 185 North Wabash Avenue. Dr. Paul Van Pernis was elected President of the Board, Miss M. Olson of Minneapolis War Memorial Blood Bank, secretary; Dr. John D. Lemar of Fargo, North Dakota, treasurer; Mrs. Cobb, who was a stenographer in Mr. James Leary's office, was selected as Executive Secretary of the Clearing House and the room previously used by Mr. John Neal was thought to be adequate for the Clearing House office at this time. Mrs. Cobb is organizing the office and by May 1st, blood banks throughout the area will be invited to participate. Mrs. Cobb was sent to San Francisco for 10 days to work with the California Clearing House. This training should be valuable in her conduct of our Clearing House Office. During the meeting of the Illinois State Medical Society, we hope to have on display an exhibit of the American Association of Blood Banks which outlines the method of operation of the Clearing House program.

Every effort has been made by your Committee to emphasize that the Clearing House is a project of the Illinois State Medical Society, yet to encourage and enlist the interests of the other ten State Medical Societies, the By-Laws specifically request their participation. Through this medium close liaison with the Clearing House Board should be achieved. We believe the Board is in safe hands and your support of another public service to the people of the state and surrounding states should not be made in vain.

Respectfully submitted,
COYE C. MASON, M. D.
Chairman.
WELLAND A. HAUSE, M. D.
ROBERT F. SHARER, M. D.
GERSHON K. GREENING, M. D.
PAUL A. VAN PERNIS, M. D.
PAUL REINERTSEN, M. D.
Committee on Blood Banks.

BOARD OF DIRECTORS OF CLEARING HOUSE
(Temporary)

Paul A. Van Pernis, M. D. (President)
Northern Illinois Blood Bank, Inc., 307 North Main Street, Rockford, Illinois.
G. Bennett, M. D., South Bend, Indiana.
E. De Gowen, M. D., Iowa City, Iowa.
Sloan J. Wilson, M. D., University of Kansas Medical Center, Kansas City, Kansas.
E. R. Jennings, M. D., Detroit Professional Blood Service, 1400 Gratiot Ave., Detroit 7, Michigan.
Miss M. Olson (Secretary)
Minneapolis War Memorial Blood Bank, Minneapolis, Minnesota.
Carroll Hungate, M. D., 535 Argyle Building, Kansas City 8, Missouri.
John R. Schenken, M. D., 36th and Cuming Street, Omaha 3, Nebraska.
John D. LeMar, M. D. (Treasurer)
Fargo Clinic Blood Bank, 807 Broadway Avenue, Fargo, North Dakota.
Wayne A. Geib, M. D., Rapid City, South Dakota.
T. J. Greenwalt, M. D., Milwaukee Blood Center, Inc., 763 North 18th Street, Milwaukee, Wisconsin.
R. Barnes (Red Cross)
Mrs. Cobb (Executive Secretary, as of March 21, 1955)

CANCER CONTROL

To the Members of the House of Delegates:

Our Committee has not seen the need for much activity on its part other than an advisory function for cancer programs carried out by the Illinois Division of the American Cancer Society, and the Illinois State Department of Public Health. Particularly, since these two organizations carry on an active campaign and consult our Committee on every significant new project contemplated.

At a recent meeting of our Committee, the activities carried out in cancer throughout the State were reviewed. The meeting of the Committee on Cancer Control of the Illinois State Medical Society was held at 6:00 P. M., Wednesday, March 23rd, 1955. Below is an abstract of minutes of the meeting.

The plan for development of cancer registries throughout the country was discussed, and the policy of activating Cancer registries was approved by the Committee. Development of Cancer registries with personnel to analyze data would certainly improve our knowledge of cancer.

The Committee regrets the fact that so many physicians state categorically, patients having cancer will always die of cancer unless it is treated. Spontaneous regression of cancer even to the point of cure is not fully appreciated by the profession. It is important that this feature of cancer be emphasized for two reasons. In the first place, spontaneous regression is very misleading to the physician giving therapy, and in fact, is the major source of authentic testimonials utilized by individuals giving worthless agents in treatment of cancer. In the second place, the patient with a seemingly hopeless cancer should not be deprived of the hope that his condition might improve in spite of the fact that the situation appears pessimistic.

The Committee reaffirms its recommendation of a few years ago, that the doctor's office is the most effective place to carry on diagnosis of cancer. It likewise encourages doctors to cooperate fully with patients requesting interval examinations for cancer even though no symptoms are present.

The Committee reemphasizes the value of programs for professional education, as being carried on by the Illinois Division of the American Cancer Society, and other organizations. Over a period of eight years, 547 physicians from downstate and a small number from Chicago have enrolled in these courses given by the Illinois Division of the American Cancer Society.

The Committee reaffirms its approval of circulation of good films on cancer to lay people as well as physicians. They are firmly convinced that a film such as, "Self-Examination of the Breast", has brought hundreds and even thousands of women with breast lesions to the physician at an early date. Likwise of importance is the constant publication of important features in the prophylaxis and treatment of cancer. The Committee is reminded that last year we approved the leaflet for publication in the Illinois State Medical Journal, calling attention to the common sites of cancer which may be discovered by routine examinations.

Dr. John A. Rogers is Director of the Illinois Division of the American Cancer Society. Dr. Rogers reports numerous activities being carried out by the Illinois Division. In addition to grants given by the American Cancer Society (National) for research, $71,200 was received from Illinois citizens for research in cancer to be carried out in Illinois. A Committee has been appointed to approve or disapprove applications for funds. The Division continued to support the program carried on to study the effects of smoking on development of cancer of the lung. Over $45,000 was spent last year on professional education. The annual, or semi-annual course in Cancer offered by the Illinois Division has been reduced from five days to three days, with an increase in attendance to 55 for the last course. Five half-time Fellowships are offered by the Illinois Division.

The Division continues to purchase issues of "The Cancer Bulletin," and "CA," "a bulletin of cancer progress," for physicians in Illinois. The number sent out has been increased from 3,450 to 4,250. Anyone who is not receiving a copy of these two journals and wishing to have them sent to him should write to Dr. John A. Rogers, of the Illinois Division.

Professional education was extended to the nursing profession. This year a two-day symposium on Cancer is being given for Occupational Health Nurses.

Lay education continues to be one of the important functions of the Illinois Division. This is carried out by the main office of the Illinois Division and 80 downstate Chapters, which requires the assistance of a large number of individuals, very few of whom receive remuneration.

During the past year cooperation of the Air Force was obtained in conducting within their installations a cancer control program for military and civilian personnel. A very effective program was carried out in all four Air Force units in the State. This same type of program is being offered for the 26 Army installations in Illinois.

The American Cancer Society does not own or operate any Cancer Clinics. This is clearly the responsibility of the hospital within which the Clinic exists. However, during the past year over $38,000 was expended in the support of Cancer Clinics throughout the city and state. Considerable aid was also given the Visiting Nurses Association for the care of terminal cases.

Dr. G. Howard Gowen remains Deputy Director of the Division of Hospitals and Chronic Illness for the Department of Public Health in Illinois. Their activities in the field of cancer may be summarized as follows: Financial support was given to 28 cancer diagnostic clinics throughout the state. A new Clinic began operation at St. Mary's Hospital in Centralia in December 1954. In these clinics 3,847 patients were examined for cancer. Of this group 1,724 proved to be malignant. Follow-up was carried through on 5,868 patients in these Clinics.

"A tissue diagnostic service for medically indigent patients continued as in the past, and during the year 3,290 biopsy specimens were submitted by physicians. In addition to the above there were 98 exfoliative cytological examinations made on patients unable to pay.

"The cancer registry program in down-State general hospitals continued to be pushed, and now there are sixteen registries in hospitals, which is an increase of seven over 1953. All of these are reporting statistical data to our central cancer registry. The central cancer registry maintained by the Bureau of Cancer Control now has on file 15,673 cases of cancer. For two years we have been attempting to employ a statistician in order that we might produce an analytical report of the data on hand, but unfortunately we have been unable to find such a person. It is hoped that by the end of 1955 our staff will include a statistician.

"During the latter part of 1954 in accordance with the general opinion of the radiologists that readings by two different persons of chest x-ray survey films is an important means not only eliminating unnecessary suspects but also identifying early pathology, plans were made in cooperation with our Division of Tuberculosis Control whereby we pay and provide a second reader of survey films with the specific intent of attempting to find more and earlier cases of cancer of the lung.

This program officially went into action January 1, 1955."

Respectfully submitted,
Warren H. Cole, M. D.,
Chairman.

Thomas C. Galloway, M. D.
Edwin F. Hirsch, M. D.
Carl E. Clark, M. D.
Russell M. Jensen, M. D.
James Majarakis, M. D.
Josiah J. Moore, M. D.
Patrick H. McNulty, M. D.
J. B. Moore, M. D.
Committee on Cancer Control.

CARDIOVASCULAR DISEASE

To the Members of The House of Delegates:

This committee met once, on February 27, 1955. Members present were Dr. Warner H. Newcomb, Dr. James A. Walsh and Dr. Geza de Takats. Dr. Warren F. Pearce and Dr. Louis N. Katz were unable to attend.

The meetings of the Cardiovascular Section at the Illinois State Medical Society are increasingly successful. This year Dr. Thomas Austin is chairman and Dr. Chauncey Maher is secretary.

During this committee's short life one of its major preoccupations has been liaison between various agencies interested in cardiovascular disease. These include the Illinois Heart Association, the Chicago Heart Association, the Illinois Public Health Service, the Division of Crippled Children, and others. Some contribution has been made to aid the efforts of these groups to cooperate with each other and with several County Medical Societies. This year the various agencies are having no difficulties in cooperation and your committee felt no need for liaison efforts on its part existed. We should remain alert to the possibility of future need in this field however. State and local heart associations are growing rapidly. As their activities increase, help in coordinating their efforts with those of public agencies and county medical societies will probably be indicated at times.

Rehabilitation of patients with cardiovascular disease is an urgent problem. Several agencies are active in the field but the public good would be advanced if activities were expanded and if the profession and the public were made more aware of the possibilities of rehabilitation. The committee has discussed this matter and has sought the advice of Dr. Oglesby Paul, who has a great interest in the problem. In addition to several agencies interested in the rehabilitation of cardiac patients, there are others interested in other aspects of rehabilitation. The committee was able, off-hand and without study, to name more than a dozen groups presently active in this state. We feel, as stated above, that the rehabilitation of cardiac patients should be advanced, but that efforts in this direction will be more fruitful if rehabilitation efforts in all fields are better coordinated. We recommend that the Society provide leadership in this direction. One early task would be a study of all available services in the field. After their activities and objectives are explored consideration should be given to possibilities of increased service and efficiency through cooperation. Special interests of various medical fields and various agencies such as public assistance groups, industry, labor, and insurance companies should be fully considered. It should not be the object of the society to impede or constrict the efforts of any special interest groups, but rather to assist and extend their efforts. Some of their activities involve duplication, for example the maintenance of employment contacts for handicapped workers is unnecessarily duplicated in some instances. Further study would certainly be fruitful.

This committee raises this issue in its present nebulous stage because it obviously extends outside the field of cardiovascular disease. The interests of the Committee on Physical Medicine and Rehabilitation are certainly involved. Perhaps other committees are active or interested in this field. Some other presently constituted committee augmented by representatives of special interest groups might undertake the study, a new *ad hoc* committee might be formed, or the Committee on Cardiovascular Disease might be expanded. Currently our recommendation is that the subject be pressed by an appropriate committee.

Your committee has considered proposed legislation to amend the Workmen's Compensation Act to extend the second injury fund to include chronic disease.

The second injury fund makes contributions to death or disability benefits for workers partially disabled by one injury who then sustain another injury compensable under the Workmen's Compensation Act. This makes it possible for employers to hire people who are partially disabled because of an injury, without being susceptible to unusual claims because of a later injury.

The new bill would abolish the second injury fund and create a new fund which would cover both the old second injury cases and the new category of chronic disease. This new bill is being sponsored by the Chicago Heart Association, the Illinois Heart Association, and a number of similar organizations throughout the state. We do not have a copy of the bill, which I believe has not yet been introduced, but the Committee feels that it would be desirable for the Illinois State Society to endorse the bill in principle, reserving specific action until the details of the bill are known.

Respectfully submitted,
Wright Adams, M. D.
Chairman.
Warner H. Newcomb, M. D.
Co-Chairman.
Geza de Takats, M. D.
James A. Walsh, M. D.
Louis N. Katz, M. D.
Warren F. Pearce, M. D.
Committee on Cardiovascular Disease.

CONSTITUTION AND BY-LAWS

To the Members of The House of Delegates:

Three (3) members of The Committee on Constitution and By-Laws met informally on March thirteenth, 1955.

There does not appear to be any need for changes in the Constitution or By-Laws at this time.

Respectfully submitted,
Warren W. Furey, M. D.
Chairman.
Arthur F. Goodyear, M. D.
Jacob E. Reisch, M. D.
O. W. Rest, M. D.
Committee on Constitution and By-Laws.

CRIPPLED CHILDREN'S CLINICS

To the Members of the House of Delegates:

Crippled Children's Clinics have continued to increase in number and become wider in scope since their early sponsorship and supervision by Dr. East in the 1920's. They are known to the public in general and they are recognized by the local medical organizations. Many lay groups give aid freely.

Satisfactory hospital connections are well maintained so that necessary hospitalization and surgery can be effectively carried out as need arises, without prolonged delay.

It is the policy of the Illinois State Medical Society that these services be limited to crippled children who are destitute. The attendance at these clinics by members of the local medical societies is appreciated and their assistance, advice, and participation is encouraged.

It is recognized that helpful beneficent organizations are extending their services and aid thruout the State. These include the National Foundation for Infantile Paralysis, the Illinois Association for the Crippled

(Easter Seals), the Illinois Elks Association Crippled Children's Commission, the Shriners' Crippled Children's Organization, and others.

The clinics which are held thruout the State are:

THE ELKS ASSOCIATION

In 1954, 65 scheduled clinics were held in the following towns:

Lawrenceville	(1)	Canton	(4)
Robinson	(1)	Streator	(4)
Olney	(1)	Lincoln	(6)
Mt. Carmel	(1)	Mattoon	(2)
Carlinville	(1)	Charleston	(2)
Pana	(1)	Ottawa	(3)
Taylorville	(1)	Paris	(4)
LaSalle	(6)	Anna	(1)
Galesburg	(4)	Carbondale	(1)
Kewanee	(5)	Herrin	(1)
Champaign	(4)	Murphysboro	(1)
Freeport	(4)	West Frankfort	(1)
Danville	(4)	Benton	(1)

Of the 2,162 examinations given during the year ending April 30, 1954, 1,131 were given at 65 downstate clinics, an average of 17 plus per clinic. The rest were seen at the University of Illinois Hospitals where there are clinics practically every day.

DIVISION OF SERVICES FOR CRIPPLED CHILDREN:
University of Illinois

Location	*No. Clinics*	*Total Attnd.*
Total	197	9,993
Peoria	24	1,435
East St. Louis	14	968
Springfield	12	742
Rockford	12	597
Alton	9	556
Bloomington	12	529
Hinsdale	12	448
Chicago Heights	6	288
Quincy	4	263
Mt. Vernon	4	260
Evergreen Park	6	250
Sterling	4	217
Danville	4	215
Flora	3	209
Elgin	6	203
Litchfield	4	207
Aurora	6	203
Joliet	6	192
Macomb	4	175
Cairo	4	162
Evanston	6	133
Carrollton	2	124
Fairfield	2	123
DuQuoin	2	116
Jacksonville	2	109
Clinton	2	104
Centralia	2	98
Shelbyville	2	91
Anna	2	88
Salem	2	85
Tuscola	2	78
Casey	2	74
Pittsfield	1	74
Effingham	1	74
Shawneetown	1	73
Vandalia	2	65
Watseka	1	65
Metropolis	1	62
Carmi	1	59
Chester	1	46
Sparta	1	44
Monticello	1	42
Rosiclare	1	41

CRIPPLED CHILDREN'S CLINICS IN THE CHICAGO AREA:

Of the number of Crippled Children's Clinics in Chicago that are known to function, the following are those who responded to our request for information.

Northwestern Medical School:
- Weekly Clinics 150
- Approximate no. crippled children per clinic ... 4

The University of Chicago:
- Clinics held daily 2
- Approx. no. crippled children per clinic..30-35 week.

Mount Sinai Hospital:
- Orthopaedic clinics held weekly 2
- Approx. 1 or 2 crippled children seen each session.

The Children's Memorial Hospital:
- Orthopaedic clinics twice weekly for 52 weeks.
- Approx. no. crippled children per clinic 35

The Central Free Dispensary of West Chicago:
- Orthopaedic clinics held weekly 3
- Visits to this clinic for crippled children ..... 165 or 3.1 visits per session.

University of Illinois:
- Weekly clinics held in 1953 9
- Approx. no. crippled children per clinic 10-15

St. Luke's Hospital:
- Weekly clinics held in 1954 3
- Average no. crippled children per clinic 4

Michael Reese Hospital:
- Weekly Orthopaedic clinics 2
- Approx. no. of orthopaedic cases seen 16

Cook County Hospital:
- Orthopaedic clinics held weekly 6
- Clinical visits 1,828

Shriners' Hospitals for Crippled Children:
- Number of weekly clinics held in 1954:
  - Regular clinic 48
  - Cast clinic 52
- Approx. no. crippled children per clinic,
  - Regular clinic 54
  - Cast clinic 8

CRIPPLED CHILDREN'S CLINICS IN CHICAGO:

These clinics all have adequate hospital connections. The majority of them are held in institutions which have medical school associations. They are staffed by qualified Orthopaedic Surgeons. This arrangement facilitates the proper care of the crippled child from the time he is first seen; thru his admission to the hospital, the operative period and finally thru his post operative care. Follow-up care later is carried out.

Downstate Clinics are held in the majority of Counties and in all sizeable communities. Their accessibility is such that all crippled children can be brought to them regularly. Most of them are held periodically several times yearly.

Since last annual report your Chairman met with the Program Consultant Mrs. E. Jameson, of Illinois Association for Crippled. They now have 15 separate treatment centers, established and functioning. They are anxious to have local physicians take an active part in the guidance of these clinics.

An addition to the membership of the Crippled Children's Clinic Committee has been appointed: Dr. James J. Callahan, Professor of Orthopaedic Surgery, Loyola Medical School.

FRANK G. MURPHY, M. D.
Chairman.
HERBERT R. KOBES, M. D.
GERARD N. KROST, M. D.
HUGH COOPER, M. D.
JOHN J. FAHEY, M. D.
JAMES J. CALLAHAN, M. D.
Crippled Children's Clinic Committee.

TO INVESTIGATE CORONER'S LAW

To the Members of The House of Delegates:

The Illinois State Medical Society in 1952 appointed a committee to examine the possibilities of a constructive revision of the Coroner's Act of 1874 which would afford the Coroners of Illinois the advantages of a system of forensic pathology. The members of this Committee are Doctor Harlan English of Danville, Doctor C. Paul White of Kewanee, Doctors S. A. Levinson and Edwin F. Hirsch (chairman) of Chicago, and John Neal (legal advisor) of Chicago. Later Doctor Franklin Moore of Chicago and Walter Oblinger (legal advisor) of Springfield were added. Toward the end of the Session of the Legislature in 1953 a bill was presented for hearing but was not introduced for a vote. In the meantime the Association of Coroners of Illinois also became interested in a revision of the Coroner's Act. Representatives from this group and members of the Committee of the Illinois State Medical Society joined in discussions of ideas in Chicago on December 5, 1954 and concluded that the objectives of both groups could be consolidated into one bill. At a subsequent meeting of both groups in Chicago, minor differences were adjusted and clarified.

Accordingly a major bill and a supplemental bill were prepared and were approved by both groups. Any legislative revision of the Coroners' Act must cover all counties of the State. To do this for the large State of Illinois and the great range of Coroner work-loads in counties, a division of counties on the basis of population was suggested. In the proposed bill, counties of more than 500,000 population are designated as Class I Counties, and those of not more than 500,000 population as Class II Counties. In cases referred to any Coroner, he will make a preliminary examination into the circumstances of the death and with the aid of a coroner's physician attempt to ascertain the cause of death, either by necropsy or other investigations. Necropsies for coroners will be performed by physicians duly licensed to practice medicine in all of its branches, and wherever possible by one with special training in pathology. In Class I Counties such medical examinations or necropsies shall be performed by physicians appointed or designated by the Coroner, and in Class II Counties by physicians appointed or designated by the Director of the Illinois Department of Public Health.

The proposed bill also defines more clearly the cases of death which belong to the jurisdiction of the coroner; it protects the coroner and the coroner's physician against civil or criminal liability in the discharge of their duties; and leaves with the county the cost of the examinations. The bill directs that a coroner's jury shall be summoned in cases of apparent or suspected suicide, homicide or accidental death but in other cases at discretion of the Coroner. This provision can eliminate many farcical jury hearings.

A companion bill provides that necropsy service to the Coroners of Class II Counties of the State of Illinois, be established in the Department of Public Health with an Advisory Board appointed by the Governor. Under this plan, coroner's physicians are designated by the Department of Public Health to cover regions of Class II Counties throughout the State. A coroner's physician covering a region of counties will be called upon for necropsy service by the coroners of such a region. The Advisory Board appointed by the Governor will have nine members, three of them licensed physicians, three of them duly elected Coroners, and three of them lay representatives with at least one from the legal profession and acquainted with forensic medicine. A modest appropriation for expenses connected with meetings of the Advisory Board is included.

The proposals of the bill revising the Coroner's Act are sound and beneficial. In effect they would mark the beginning of a constructive program in which forensic pathology can develop as a forceful aid to the Coroners of Illinois in the discharge of their duties. Any constructive project in the health of a community must have a beginning. It does not realize full fruition without tedious effort, deliberation and time. Given these, results of great value can happen.

Edwin F. Hirsch, M. D.
Chairman.
Samuel Levinson, M. D.
Harlan English, M. D.
C. Paul White, M. D.
Franklin Moore, M. D.
Committee to Investigate Coroner's Act.

DIABETES

To the Members of The House of Delegates:

No meetings of the Committee on Diabetes of the Illinois State Medical Society were held this year. Dr. Robert W. Keeton resigned as chairman. The committee consisted of:

Robert W. Keeton, M. D.
Thomas D. Masters, M. D.
George M. Parker, M. D., Chairman.
Henry T. Ricketts, M. D.

Diabetes detection and education continued in the state in the past year.

1. The State of Illinois Department of Public Health had their usual exhibit and urine testing project at the 1954 Illinois State Fair and also participated in several county fairs through the West Central Region of the Illinois Department of Public Health.

2. In November 1954 during Diabetes Detection Week, the Adams, Jackson and Peoria County Medical Societies in cooperation with their local Departments of Health held diabetes detection drives.

3. The Committee endorsed a program initiated by the State of Illinois Department of Public Health to hold courses of instruction for public health physicians in Illinois so that they could better aid the County Medical Societies in planning and administering diabetes detection programs.

Respectfully submitted,
George M. Parker, M. D.
Chairman.
Robert W. Keeton, M. D.
Thomas D. Masters, M. D.
Henry T. Ricketts, M. D.
Committee on Diabetes.

EDUCATIONAL COMMITTEE

To the Members of the House of Delegates:

The Educational Committee met in the Chicago Office on October 23, December 12, January 15, and April 23.

Television:

We regret that, at this time, we cannot say positively that we have returned to television with our own program. This is a distinct disappointment to all members of the Educational Committee. We were the first state society to attempt television as a medium for health education, having programmed for the first time in October, 1948. Beginning December 5, 1948, the Committee presented weekly telecasts for five and a half years. As pioneers at a state society level, we have helped our sister states and county medical societies enlist this valuable medium in telling the story of health. It is interesting that the Committee met opposition in its early use of this medium. And more interesting that the opposition, now that they have television in their own communities, is now the most critical that the Committee is not now on the air with its own program. This same opposition, recognizing television as a valuable medium of communication using the com-

bined influences of sight and sound, is forgetful, of course, that as a pioneer, the Educational Committee, through its telecast, won an award in its first year, and over five and a half years significantly received widespread and favorable publicity from numerous sources. The Committee's experiences have helped other medical societies to avoid pitfalls of professional and lay criticism—the type of criticism, because of careful planning and organization, the Committee did not encounter.

On Wednesday, March 23, Mr. Jay Faraghan, program director of WGN-TV, called the Committee to say that plans were being worked out to return our program, "How's Your Health," to the air. He asked Ann Fox, Secretary of the Educational Committee, to be alerted for a comparatively short notice. Thus far, we have had no other word.

We have arranged for appearances of physicians, having scheduled fifty-four for the telecast, "All About Baby," a Jules Power Production, featuring Ruth Crowley, R. N. This is presented on WGN-TV, Channel 9. Physicians appearing on"All About Baby," because it is commercially sponsored, receive fifty dollars an appearance. No physician is invited a second time in less than a year. The Educational Committee reviews all commercials that are used on "All About Baby."

One physician was scheduled to appear on a morning telecast on WBKB, Channel 7, February 8, to present the highlights of the Clinical Conference of the Chicago Medical Society. The Secretary would have been happy to have arranged more of these, had she been requested sufficiently in advance of the Conference.

The Secretary cooperated with the American Medical Association and Dr. Frank Warren in presenting a television program during the American Medical Association PR Conference. This was sponsored by Warner-Chillco, Inc.

She attended the preview of "The Medic," sponsored by Dow Chemical Company under the auspices of the Los Angeles County Medical Association. She also was one of the panel discussants in a TV Conference sponsored by the Illinois Society of Public Health Educators at Allerton Park, Monticello, Illinois, December 9-10 and served as a recorder in the session on health during the Midwestern Conference on Educational Television at the Illinois Institute of Technology, March 24-25.

The Secretary also assisted the Illinois State Department of Public Health and Dr. George L. Drennan, Chairman of the Subcommittee on School Health to the Educational Committee, by preparing television script material for the Conference on School Health in Champaign, Illinois.

She arranged for four television appearances of out-of-state pediatricians as a public relations gesture for the American Academy of Pediatrics.

The Committee has worked with William Henricks Associates in a proposed program on "Your Children's Problems." Because he is out of private practice, special appear as moderator of this program, which, at this time, is only in the production stage and has not been aired publicly.

The Secretary has been in touch with the staff of the Educational Television Station, Channel 11, WTTW (Window to the World). Copies of the Committee's materials dealing with television, such as program ideas, scripts and photographs, have been submitted to the station in booklet form. The House of Delegates, in May, 1954, voted that $1,000 be sent to WTTW. This has not been done.

The Secretary attended the Videclinic at the Palmer House on "Management of Coronary Artery Disease," sponsored by Smith, Kline and French Laboratories and the American Medical Association, and the Teleclinic of the American Academy of General Practice at the Sheraton Hotel.

One physician who had been asked to serve as moderator in a proposed television program requested guidance from the Educational Committee. Since he was in part-time private practice, he was urged to abandon the project until he was completely out of private practice because of the commercial aspect.

This summary of television contacts is an indication that the Educational Committee retains its interest in television as an effective instrument to disseminate health information.

Radio:

Fifty-five physicians have been scheduled for the series, "Your Doctor Speaks," which is a weekly program presented by the Educational Committee in cooperation with FM Station, WFJL, on Thursday nights at 7:45 p. m. Although it was announced that this station was to go off the air December 31, the station is still operating with daily air time of five hours.

One physician appeared on "Your Doctor Speaks" in a direct interview with a staff announcer on the history and features of the Clinical Conference of the Chicago Medical Society.

The Secretary of the Educational Committee goes to the studio each week with the physician cutting the transcription. This procedure was adopted more than a year ago and has helped to "liven" up the presentation. The physician is usually unfamiliar with the technical detail, and the Secretary's presence with her familiarity of studio technique contributes to a more conversational tone to the broadcast instead of the straight reading tone that usually prevailed, particularly with those physicians who were appearing for the first time before a "mike."

The Committee authorized the Secretary to prepare some spot announcements on health information for radio stations. Because of the emergencies that have existed in the Chicago Office, this has not been completed.

Health Talk:

"Health Talk," the publication on timely topics of health, continues in popularity. A total 1,017 issues of Health Talk go each week to newspapers in Illinois, councilors, branch officers of the Chicago Medical Society, secretaries of county medical societies, a few physicians and nurses and other state medical societies. This gives an aggregate total of 4,407 a month. This weekly issue is a double-spaced, mimeographed two-page story to facilitate the handling by the weekly newspapers. A total of 3,895 individuals, health chairmen of Parent-Teacher Associations, health chairmen of the Federation of Women's Clubs, health educators, health agencies, hospitals, libraries, Young Men's Christian Associations, Young Women's Christian Associations, nurses and schools receive two issues each month, or 7,790. Of this number, 951 are schools. It is interesting that forty-two parochial schools were added to the mailing list in March on their individual request.

A certain number of persons and house organs make up a "special" list. This list was created to avoid overlapping and duplication in individual names and organizations. Eight permanent offices representing the Springfield Tuberculosis Association, Illinois Public Aid Commission, a county nurse, the Alcoa Mining Company, Parent-Teacher health chairmen, Young Men's Christian Associations, Egyptian Health Department and a department store receive 832 copies for individual distribution. In this same "special" classification, nine schools receive 666 issues, sixty Health Improvement Association permanent offices receive 2,722 issues, and eighty Home Bureaus receive 4,118.

Because of the duplication of names active in Health Improvement Associations, Farm and Home Bureaus, every attempt has been made to send Health Talk only to permanent offices where the secretary then forwards the publication to individuals. There are now 193 in-

dividuals and permanent offices receiving over 300 issues of Health Talk each month for this type of distribution to individual health chairmen of the respective groups.

Thus the weekly mailing and the monthly mailing list, together with the "special" monthly list, show an aggregate total of 20,535 issues of Health Talk being mailed each month. This is separate from the numerous requests that are being received daily for certain issues. Apart from the regular mailing list during the past year, 115 persons requested 2,150 additional copies of Health Talk on a wide variety of topics. The most popular were "Superstitions About Health," "Be Prepared for Emergencies," "Atomic Medicine," "Do You Have Diabetes," "Multiple Sclerosis," "Growing Old Gracefully," "Drug Addiction," "Personal Grooming Important," 'Your Child Grows Up," "Helping Ourselves to Happiness," "Help Your Child Face Surgery," and "Feeling of Inadequacy."

For the most part, the total of 115 included teachers in parochial, public and private schools. The Director of Finance of the City of Bloomington requested five special issues. The Hawthorne Station of the Western Electric Company asked for twelve issues of a certain Health Talk after receiving the regular one through the monthly mailing. Five hundred copies of "Nutrition Is Important" and "Ringworm of the Feet" were distributed at the fall workshop of the Illinois Association for Health, Physical Education and Recreation, Chicago District. This workshop developed highlights for health teaching with emphasis on audio-visual aids.

Sixty-eight requests to be placed on the mailing list came from the following states: Alabama, Arkansas, California, Colorado, Indiana, Iowa, Massachusetts, Michigan, Minnesota, New Jersey, New York, Ohio, Oklahoma, Pennsylvania, Texas, South Dakota, Virginia, West Virginia, Wisconsin and Canada. The Committee has agreed generally that out-of-state requests be restricted but fufilled when a teaching institution was involved, such as those coming recently from the Board of Education of the City of New York; Northwestern College, Orange City, Iowa; Augustana College, Sioux Falls, South Dakota; Library, Centennial High School, Pueblo, Colorado; Health Education Consultant, State of West Virginia Department of Health; and Stanford University Library, Stanford, California. One school nurse wrote: "The principal of our school suggested that I obtain enough copies of Health Talk so that each of our forty-two teachers may have one."

The total postage for Health Talk alone, which is handled at a third-class rate, is $107. The individual mailings going to the special permanent offices vary from ten issues to 165 issues. Hence, the mailing costs vary from 6 cents to 39 cents, or a total of $17.50 for the entire "special" list, as this group is classified.

Joan Barlow, R. N., Squibb Nurses' Notes, asked if she could publicize Health Talk available to all nurses or just those in Illinois. She was told that for economic reasons, the mailing list must be restricted to Illinois.

The clerical handling of Health Talk requires twenty hours each week of a part-time employee. The detail attached to the work is important in that the handling must meet certain postoffice requirements. At one meeting of the Educational Committee, all members studied this operation and were amazed at the extent of work and care required for meeting these postal requirements.

Response to Health Talk is reflected in the following: The Chicago Daily News used the Health Talk on "Vacations" and one titled "Is Your Child Ready for School?" on July 10 and August 19, 1954, respectively. It also used "Temperature and You" on October 30, 1954. Science Newsletter used the issue on "Hoarseness," July 21, 1954. Blueprint for Health reproduced "When Jaundice Develops" and "The Esophagus" in one issue. Susan Myers, editor of this Blue Cross publication, wrote: "Hope you don't go out of business, as we can't get to press without a Health Talk or two."

One University of Chicago professor wrote a complimentary letter on Health Talk, but taking exception to our saying "a relatively constant temperature of 98.6° F."

One physician wrote: "I want to take part in congratulating you on the splendid work you are doing on your paper, Health Talk."

A secretary in India asked to be placed on the mailing list, stating they had 350 units representative of 40,000 children.

An arrangement is now being worked out whereby Health Talk will be distributed by Welcome Wagon, Inc., representatives. Since the representatives live in scattered areas, the national office proposes to notify the individual representatives to write individually to our office. The Committee believed that an issue on "How to Locate a Physician" would be interesting, but at a meeting of the forty representatives in the Chicago area, the issue on "Helping Ourselves to Happiness" was the one that they thought would be the most inspiring.

The Committee would like to remind the House of Delegates that Health Talk has won six awards, locally and nationally. Competition is out of the question now since original copies in press writing contests must be accompanied by newspaper and magazine clippings. The clipping service has been abandoned because of the expense.

For the first time this year, the Women's Auxiliary to the Illinois State Medical Society is including two issues of Health Talk in their fifty convention packets for distribution to each Auxiliary. The issues selected by Mrs. Albert Kwedar, President, were "Helping Ourselves to Happiness" and "Help Your Child Face Surgery."

One nurse wrote: "The copy of Health Talk covering contagious skin infections came in today and, as per usual, just at the right time. We have an employee with impetigo contagiosa, and when he was given an opportunity to read your article and take it home for his mother to read, really good hygiene resulted and not just so many words. It meant more to them and the protection to the family became vital. This has happened in more than one instance on other subjects, and I certainly give you many heartfelt thanks. Whenever I need help to put a subject over, Health Talk is one of my first sources. Always timely, concise, understandable and minus the 'scare element'."

A school nurse in Harrisburg wrote she regretted that she had never taken time to send an expression of appreciation of this service. She said, "though I have appreciated the context of Health Talk, I have also admired the beautiful and free use of words by the writer. Please pass my expression to the proper person or persons."

The Administrator of Antelope Memorial Hospital in Neligh, Nebraska, requested permission to reproduce Health Talk in their local newspapers. She promised full credit to the Educational Committee. Permission was granted, and thus far, we have not heard whether the nun has been able to develop these arrangements.

A request came from the Principal of University School, Carbondale, Illinois, for 500 copies of the March 15, 1955, issues of Health Talk on "The Feeling of Inadequacy."

The Health Counselor at Blum's, Inc., who is currently receiving forty copies each month for distribution to the employees, asked for an additional twenty-five copies of the issue, "Helping Ourselves to Happiness."

The Committee has received Council approval to select twenty-five issues of Health Talk that have proved extremely popular to be published in booklet form. Unfortunately, because the office has been handicapped in the past several months by both illness and insufficient help, this project has not been completed.

PACKAGE LIBRARIES:

Three years ago, the Educational Committee discontinued its package library service in which it made available to students and physicians packages of material on a given subject. This project was abandoned because the requests for the service had declined in the past number of years. For this reason, it is interesting to note that twenty-two requests came in the last year for package libraries on a lending basis. These were all referred to the Bureau of Health Education of the American Medical Association.

SPEAKERS' BUREAU:

A pamphlet in mimeographed form is being planned to offer a list of subjects to be used by lay groups. This would supplement the few topics that are now used on the reverse side of Health Talk.

It is interesting to report that more "thank you" letters have been received in the past year than previously. Both in appreciation for the service of the Educational Committee in providing a speaker and for the ability of the speaker. These letters are all sent to the speaker with a "thank you" note from the Committee.

One group sent the Educational Committee a check for fifteen dollars as a token of appreciation. This check was returned to the club with an expression of thanks and a wish that it be turned over to one of the club's worthy projects.

A total of seventy-five speakers were scheduled for talks before men's and women's clubs, Parent-Teacher Associations, Lions and Kiwanis Clubs, Community Center, evening school classes, church groups, Women's Auxiliaries, a school of nursing, home and school associations, Health Improvement Associations, Mothers' Club, and Youth Week. The eight speakers scheduled for Youth Week were in cooperation with the Chicago Medical Society and the Chicago Board of Education.

Thus, the Educational Committee scheduled 182 persons to appear before the public in its varied activities, either through the Speakers' Bureau, television or radio.

MISCELLANEOUS:

The Secretary has had several meetings with Mrs. Alice Scroggins, district manager of Welcome Wagon, Inc., incidental to the distribution of Health Talk. Special consideration must be given to the working arrangement with Welcome Wagon because they require a reciprocal agreement, asking, among other information, that the cooperating person or agency make available the birth dates of newly born infants. The Educational Committee does not see how this could be worked out advantageously, since it would be almost an impossibility to have every physician reporting a birth and similar information to the Educational Committee or to Welcome Wagon, Inc.

The Secretary attended one Joint Committee on School Health meeting at the Institute of Medicine, and several meetings of the Illinois Chapter of American Women in Radio and Television. The national organization of this group will hold a meeting in Chicago May 5-8, which the Secretary will attend and cooperate as a member of the Exhibits Committee. This is an extremely valuable contact.

She addressed the Women's Auxiliary to the Peoria Medical Society, March 15, on the occasion of its fifteenth birthday and attended two meetings of the Chicago Regional Parent-Teacher Association, the Public Relations luncheon of the Women's Auxiliary to the Chicago Medical Society, the Annual Secretary's Conference in Springfield, March 27, and will address the Women's Auxiliary to the Cook County Physicians' Association, May 28, at which more than 200 members will be present.

Our Chicago Office has handled the work for the Medical Economics Committee and prepared each month the News of the State and Deaths for the Illinois Medical Journal. In addition, special services were rendered to Maurice M. Hoeltgen as Chairman of the Committee on Arrangements for the 1955 Annual Meeting.

Miss Fox has attended the meetings of the Medical Economics, Scientific Service and Educational Committees and has rendered service to all of them in the way of preparing agendas and reports as well as assisting in the preparation of original addresses for individual physicians before lay and scientific groups. Special services have been given to the Woman's Auxiliary of the Illinois State Medical Society, particularly in the way of mimeographing reports and agendas.

This report reflects only an outline of the activities of the Educational Committee. It does not reflect the amount of time expended by the individual members of the Committee in fulfilling their functions nor in reviewing the material that is constantly being routed to it by the Secretary. All copies of Health Talk, radio talks and special written requests for information that must have a thorough consideration are individually reviewed by the Committee, which is also kept informed of daily happenings through a letter from Miss Fox.

The Educational Committee has endeavored sincerely to fulfill all obligations in meeting the objective for which it was created: the dissemination of sound health information. The Committee wishes to express its appreciation for the work of its Secretary, Miss Ann Fox, and to Mrs. Kay Simmons. Their loyalty and efficiency have made the Committee's accomplishments possible. The Committee wishes to thank Dr. Harold M. Camp, Secretary of the Illinois State Medical Society, Mrs. Frances Zimmer, his Executive Assistant, and all other members of the Monmouth Office, as well as Mrs. Esther Fraser, Assistant Secretary of the Chicago Medical Society, and her staff for their continued cooperation in the work of the Committee.

The Committee, in submitting this report, is deeply aware and appreciative of the confidence and trust placed in it by the Council and the House of Delegates.

Respectfully submitted,

CHARLES P. BLAIR, M. D.
Chairman.
KARL L. VEHE, M. D.
Co-Chairman.
GEORGE BYFIELD, M. D.
GEORGE L. DRENNAN, M. D.
HARLAN ENGLISH, M. D.
LESTER S. REAVLEY, M. D.
MISS ANN FOX, *Secretary.*
The Educational Committee.

SUB-COMMITTEE ON SCHOOL HEALTH

TO THE MEMBERS OF THE HOUSE OF DELEGATES:

The Sub-Committee on School Health, which is a sub-committee of the Educational Committee of the Illinois State Medical Society, wishes to report as follows:

The committee met prior to the meeting of the Council on January 16, 1954, with the following members present: J. L. Reichert, Co-Chairman, Kenneth Nolan, W. W. Fullerton, and Arthur Shafton. The activities of the committee for the past year were reviewed at this meeting, and while there had been no formal meeting of the committee, the committee had assisted with two conferences on School Health, one in Urbana and one in Carbondale.

It was the concensus of opinion of the committee members that the activities of the committee, for at least the next six months, should be that of encouraging and urging physicians to take part in School Health Activities, leading up to an anticipated conference on Physicians and Schools in 1956.

The chairman of the committee has had numerous conferences with various organizations and specialists of organizations regarding school health as it affects the school children in the State of Illinois.

Respectfully submitted,
GEORGE L. DRENNAN, M. D.
Chairman.
JOHN L. REICHERT, M. D.
Co-Chairman.
ARTHUR L. SHAFTON, M. D.
W. L. CRAWFORD, M. D.
KENNETH S. NOLAN, M. D.
W. W. FULLERTON, M. D.
Sub-Committee on School Health.

ETHICAL RELATIONS

TO THE MEMBERS OF THE HOUSE OF DELEGATES:

There have been no cases referred to this committee for action during the past year.

Respectfully submitted,
*ARTHUR C. TAYLOR, M. D.
Chairman.
CHARLES ALLISON, M. D.
V. BURDETTE ADAMS, M. D.
Committee on Ethical Relations.

---

* *Deceased.*

FIFTY YEAR CLUB

TO THE MEMBERS OF THE HOUSE OF DELEGATES:

Wishing to honor physicians who have devoted many years to the practice of medicine, the Fifty Year Club was organized in 1938. The qualifications for membership are *Fifty Years* in the practice of medicine, and a recommendation from the County Medical Society in whose jurisdiction they reside. No initiation fee or yearly dues are exacted.

Since the organization of this club over 1,000 certificates of membership and lapel buttons have been issued. The certificates of membership are signed by the President, Secretary, and Chairman of the Council of the State Society. The membership to date as of April 30, 1955, is as follows:

Chicago	232
Downstate	314
Total	546

The State Society gives a complimentary noonday luncheon for the Fifty Year Club to which all members are invited. Practically 20% of the members attend. Some are accompanied by their wives or daughters. Last year approximately 125 attended the luncheon. The guest speaker was Dr. Walter C. Alvarez.

Of the 6 physicians who have received the award as the outstanding general practitioner of the state, 5 have been members of the Fifty Year Club. The organization of the Fifty Year Club has been the incentive to cause many of the older physicians to attend our State Meetings annually. Our Fifty Year Club was the first organized in the United States. Several states have followed suit.

Respectfully submitted,
ANDY HALL, M. D.
Chairman.
E. H. OCHSNER, M. D.
E. E. DAVIS, M. D.
JULIUS H. HESS, M. D.
Fifty Year Club Committee.

INTERPROFESSIONAL RELATIONS

TO THE MEMBERS OF THE HOUSE OF DELEGATES:

The Interprofessional Council consisting of the following healing arts groups:

Illinois State Medical Society
Illinois State Dental Society
Illinois Optometric Society
Illinois Pharmaceutical Association
Illinois Veterinary Medical Association
Illinois Association of Chiropodists

have held monthly meetings which have been well attended, having from thirty to forty present at each meeting.

Medicine was well represented, with from four to eight medical men at each meeting.

Several times we have had legal representatives as well as public relations council.

The Annual Meeting, given much publicity, did not have as many present as the year before. The program was well planned, with Mr. Wood the main speaker. We also held a panel discussion, all six of the members in the Council participating.

Organization has been stressed at all meetings and some of the members have taken part in panels at other meetings, as well as individual speakers with member groups.

Dr. R. D. Barton, as Chairman of the Organization Committee has done an excellent job—sending out letters to the various branches of the Chicago Medical Society, inviting medical men as well as others, to attend the monthly meetings in order to stimulate new interest and bring out the objectives of the Interprofessional Council. These have been well received.

The exhibition plaque which was developed under the leadership of Dr. Garrison has gone the rounds of all six of the organizations' meetings, along with the Interprofessional Credo, a two paged brochure. This will again be shown at the annual meeting of the Illinois State Medical Society, held again this year at the Sherman Hotel.

Dr. Edward Piszczek has undertaken the difficult task of evaluating the problems of the Union Health Centers, on which he has reported several times.

The committee on advertising has made several reports.

The nominating committee will make suggestions for the new officers at the March meeting.

All in all the past year has shown a closer working relationship between the various groups and certainly a mutual understanding and friendliness that can only come from meeting together.

Respectfully submitted,
WAYNE B. SLAUGHTER, M. D.
Chairman.
F. LEE STONE, M. D.
Co-Chairman.
GEORGE B. CALLAHAN, M. D.
EDWARD A. PISZCZEK, M. D.
JAMES D. MAJARAKIS, M. D.
HENRY L. DUVRIES, M. D.
F. M. HAGANS, M. D.
ELLIOTT P. BURT, M. D.
Committee on Interprofessional Relations.

INDUSTRIAL HEALTH

TO THE MEMBERS OF THE HOUSE OF DELEGATES:

Since its report last year to The House of Delegates, the Committee on Industrial Health has met seven times in executive session, in addition to a number of other meetings with interested groups. The work of the Committee has been directed toward the formulation and implementation of a program to improve medical relations and to elevate the standards of medical care and administration in workmen's compensation cases. The scope of the Committee's program has necessitated the addition of seven members. Last November the present chairman was appointed to succeed Dr. Lloyd E. Hamlin, resigned, under whose able leadership much of the groundwork was laid for the present activities of the Committee.

Early in May, 1954, the Illinois State Medical Society published the Committee's report entitled "Medical Relations under Workmen's Compensation in Illinois." In the following weeks the Committee met with authorized

representatives of labor, industry and the legal profession as well as the Industrial Commission to solicit their suggestions and cooperation in the correction of abuses discussed in the report and to help provide occupationally disabled workers with a more effective workmen's compensation program.

Based upon these recommendations and further Committee study, the Committee was authorized by the Council to develop an extensive program in the field of workmen's compensation encompassing medical service, medical testimony, seminars and publications, medical reports and legislation. Specific assignments were given each Committee member. The Committee is pleased to report substantial and continuing progress in all aspects of the program and wishes at this time to report specifically on the following:

Medical Service

On December 10, 1954 the following letter was sent to representatives of industry, labor, the legal profession, insurance carriers and the Industrial Commission; also, editors of county medical society bulletins were asked to give appropriate publicity to the Committee's resolution:

"As a part of the Illinois State Medical Society's program to improve medical relations and elevate the standards of medical care and administration in workmen's compensation cases, the Committee on Industrial Health has in executive session on November 22, 1954, unanimously approved the following resolution:

" 'Whereas, the Committee on Industrial Health has been authorized and directed by the Council of the Illinois State Medical Society to investigate and report to the State Society and its appropriate component any questionable or unethical act or misconduct by a member of the medical society in connection with a workmen's compensation case, and to make available by publication in appropriate medical society builetins and by letter to the Industrial Commission and representatives of labor, industry and the legal profession, the procedures for submission of complaints on medical services and fees in workmen's compensation cases to the Committee on Industrial Health, therefore be it

" 'Resolved, that the Chairman of the Committee on Industrial Health address a letter to all above named organizations stating that James H. Hutton, Joseph F. O'Malley, F. Lee Stone, and Myron J. Tremaine, committee members, are directed by and authorized on behalf of the Committee on Industrial Health: a) to receive all formal written complaints giving specific details; to refer said complaints to proper committees of local medical societies and to follow the disposition of such complaints; and b) to receive informal complaints and communications; to take appropriate action on said complaints and communications, including, if warranted, the preparation and submission of formal or informal complaints, giving specific details, to proper committees of local medical societies and to follow the disposition of such complaints.'

"The Committee on Industrial Health therefore invites and requests your cooperation in this matter. The origin of formal or informal complaints and communications will, of course, be held in strict confidence and every effort will be made to dispose promptly of each matter. For your convenience we suggest that all communications be addressed to F. Lee Stone. M. D., 30 N. Michigan Avenue, Chicago, Illinois. His telephone number is CEntral 6-7764.

"If you wish to reprint this letter in full for the information of your members, please feel free to do so."

A state-wide press release was also issued through the cooperation of Dr. Percy E. Hopkins, chairman of the Committee on Medical Service and Public Relations, and Mr. James Leary.

As a result of this publicity, twelve written complaints were received by the Subcommittee on Medical Service within a few weeks following the releases.

Early in January, 1955, a memorandum-questionnaire was sent out to each member of the Illinois State Medical Society. The memorandum-questionnaire was designed to provide the Committee on Industrial Health with additional information on the basis of which it could:

a) Assess the correctness of information that many physicians in Illinois are reluctant to furnish medical care to injured workers or fulfill other professional obligations incidental to workmen's compensation cases.

b) In view of pending bills in the state legislature affecting choice of physician in workmen's compensation cases, formulate recommendations to the Council of the Illinois State Medical Society based on the attitude of the medical profession concerning this. At present this right is vested by law in the employer or insurance carrier.

The returns (1464) on this questionnaire as of March 15, 1955 were as follows:

Table I is a summary of 1148 replies to the Committee's questionnaire sent out January 10th and does NOT include 316 replies from physicians engaged in limited practice or who do not wish to participate in the proposed program which appears in Table II.

Table I.

1. 571 *Approve* establishment by the Council of a register of all physicians and surgeons throughout the state who are available for general services related to industrial injuries.
   53 *Disapprove.*
   10 *Have no opinion.*
   477 *Did not reply to the question but completed the remainder of the questionnaire* (from the nature of the replies to the other questions it is probable that most of the 477 thought no reply to the first question was expected.)
   37 *Qualified their replies.*

   In order to participate in this register:

2. 986 *Agreed* to accept calls from any injured employee for medical care and/or examination to evaluate disability.
   86 *Would not agree to do so.*
   42 *Did not reply.*
   32 *Qualified their replies.*
3. 1020 *Agreed* to accept calls from any employer or carrier for medical care and/or examination to evaluate the disability of an injured employee.
   42 *Would not agree to do so.*
   63 *Did not reply.*
   23 *Qualified their replies.*
4. 1077 *Agreed* to submit written reports promptly and completely in accordance with statutory provisions and/or official regulations.
   28 *Would not agree to do so.*
   28 *Did not reply.*
   15 *Qualified their replies.*
5. 1035 *Agreed* to testify upon reasonable notice before the Industrial Commission or its arbitrators in any case in which they provided medical service under the Workmen's Compensation or occupational diseases acts.
   50 *Would not agree to do so.*
   42 *Did not reply.*
   21 *Qualified their replies.*
6. 811 indicated what they consired to be *Reasonable Notice.*
   322 *Did not reply.*
   15 *Qualified their replies.*
7. *Reasonable Notice* was construed to be a *Minimum* of:
   1 day or less by 55 physicians

2 days by 55 physicians
3 days by 63 physicians
4 days by 10 physicians
5 days by 12 physicians
7 days by 293 physicians
10 days by 81 physicians
14 days by 187 physicians
15 days by 5 physicians
21 days by 13 physicians
28 days by 2 physicians
30 or more days by 35 physicians.

8. 1074 *Agreed* to accept consultation when requested by the employee or employer or when the occasion demands to request consultation promptly.
25 *Would not agree to do so.*
29 *Did not reply.*
20 *Qualified their replies.*

9. 1066 *Agreed* to submit reports to and abide by the decision of an appropriate committee of the Illinois State Medical Society in event of diputes over fees and services.
38 *Would not agree to do so.*
28 *Did not reply.*
16 *Qualified their replies.*

10. 1033 *Agreed* that the failure of a physician or surgeon to carry out any of the above obligations should place the matter before the Council of the Illinois State Medical Society for determination as to participation in future registers.
62 *Disagreed.*
37 *Did not reply.*
16 *Qualified their replies.*

TABLE II.

Analysis of 316 replies discloses:
102 *Approve* establishment of register.
15 *Disapprove.*
199 *Did not reply* to this question.

Non-Participants—167.
44 Retired.
5 Referrals only.
4 Public Health.
6 Administrative Medicine.
68 Not Interested.
10 Full-time Industrial Physicians.
2 Research.
17 Obstetrics & Gynecology.
2 Pathology.
9 Pediatrics.

Limited Practice—149.
14. Eye, Ear, Nose and Throat.
9 Ear, Nose, Throat.
24 Eye.
17 Internal Medicine.
2 Urology.
9 Psychiatry.
3 Neurology.
4 Plastic Surgery.
4 Radiology.
2 Allergy.
9 Dermatology.
3 Proctology.
2 Thoracic Surgery.
5 Orthopedics.
1 Occupational Diseases.
26 Other.
12 Signed questionnaire but did not answer any questions.
3 Answered questions but did not sign.

SEMINARS AND PUBLICATIONS

The Committee is planning to sponsor a series of roundtable discussions on matters of mutual interest to the medical profession, the Industrial Commission, labor, industry, insurance carriers and the legal profession. Upon the Committee's recommendation, the Illinois State Medical Society cooperated with the University of Chicago in presenting a series of 5 seminars on workmen's compensation in Illinois during February and March, 1955.

Plans are under way to publish a handbook to promote better understanding by physicians of their rights, duties and obligations in providing medical care for injured workers.

From time to time the Committee expects to make available to all interested parties abstracts and reprints of current papers on clinical problems and other aspects of medical aid programs under workmen's compensation laws.

An article on workmen's compensation by one of the Committee members was published in the February issue of the Illinois Medical Journal.

MEDICAL REPORTS

The Committee is also engaged in developing medical report criteria for use by physicians in workmen's compensation cases. Special attention will be given to the requirements of the Industrial Commission.

LEGISLATION

The information contained in the Committee's report on medical relations under workmen's compensation pointed up the need for a statement of guiding principles on workmen's compensation. Much study has been given to the formulation of such a statement and it is hoped that such a statement will be ready for consideration by The House of Delegates at its next meeting.

Although the Committee has discussed needed legislation at considerable length and has analyzed various bills introduced in the 69th General Assembly, no specific recommendations had been made at the time this report was written.

The Committee intends to continue its efforts to obtain official representation for the Illinois State Medical Society on the Workmen's Compensation Advisory Committee to the Judiciary Committees of the General Assembly. The Committee attributes its lack of success in this connection to date primarily to a lack of full appreciation by labor and industry of the potentials of an adequate medical aid program under workmen's compensation laws.

The Chairman represented the Illinois State Medical Society at the 15th annual Congress on Industrial Health which was held in Washington in January.

The Committee wishes to express its sincere appreciation to the Council, Dr. Harold M. Camp and the staff of the Illinois State Medical Society for their unfailing and valuable support and assistance in the past year. Special endorsement or further instructions are requested of The House of Delegates in respect to the activities of the Committee on Industrial Health.

Respectfully submitted,

FREDERICK W. SLOBE, M. D.
Chairman.
MILTON H. KRONENBERG, M. D.
Vice-Chairman.
RICHARD J. BENNETT, JR., M. D.
JOSEPH H. CHIVERS, M. D.
JAMES H. HUTTON, M. D.
JAMES D. MAJARAKIS, M. D.
CARL T. OLSON, M. D.
JOSEPH F. O'MALLEY, M. D.
CARL M. PETERSON, M. D.
EDWARD A. PISZCZEK, M. D.
V. P. SIEGEL, M. D.
F. LEE STONE, M. D.
MYRON J. TREMAINE, M. D.
Committee on Industrial Health.

LIAISON ON MEDICAL EDUCATION

TO THE MEMBERS OF THE HOUSE OF DELEGATES:

There has been the need for only one formal meeting of this committee during the current year. However, informal discussions among the committee members and with others have been carried on at various times.

In the event that problems relative to the purpose of this committee occur between now and the time

of the annual meeting, a supplementary report will be presented. Since there are a number of problems relative to the status of some groups with the medical profession as yet unresolved on both the national and state level, it would be deemed advisable to continue the structure of this committee.

Respectfully submitted,

H. Close Hesseltine, M. D.
Chairman.
Leo P. A. Sweeney, M. D.
Jacob E. Reisch, M. D.
Liaison Committee on Medical Education.

MATERNAL WELFARE

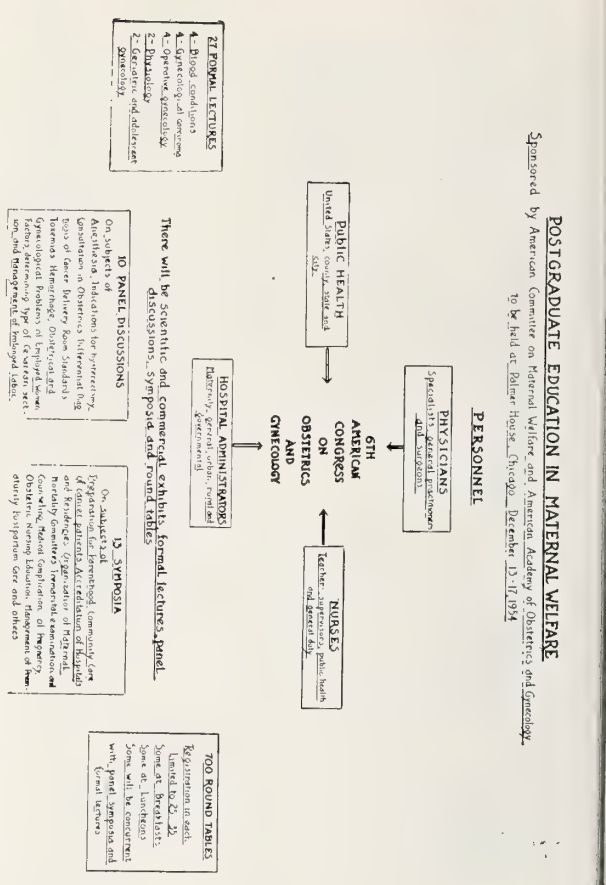
To the Members of The House of Delegates:

The Maternal Welfare Committee has continued to function in a number of ways: 1) The maternal death studies, 2) Stimulation of interest in the American Congress on Obstetrics and Gynecology held under the auspices of the American Committee on Maternal Welfare and the American Academy of Obstetrics and Gynecology at the Palmer House, Chicago on December 13-17, 1954, 3) Planning for the organization of an Illinois State Committee of which our Committee would be a sponsoring member, 4) We have recently organized a Suburban Cook County Maternal Welfare Committee which includes representatives from all hospitals in Cook County outside of Chicago. It may be of interest to the House to know that the Maternal death rate in Illinois has fallen since 1933 from seven per 10,000 to .3 per 10,000 a figure of which we may all be justifiably proud. The Committee has felt keenly the loss of Dr. Charles Newberger who had been assigned by the State Health Department to prepare the protocols for the death studies which the Committee has carried out. His place was taken by Dr. Mary Jane Otten of Springfield who was trained in a residency at Research and Educational Hospital, University of Illinois. She resigned from the State Health Department in July, 1954 and her work has been carried forward by Drs. Jack and Allen Sampson who have recently been appointed on the recommendation of Dr. Falls. The Committee demonstrated at the State Medical Society's annual meeting an exhibit showing the deaths and their causes by counties for 1953. Also an Outline of the program of the Sixth American Congress of Obstetrics and Gynecology so that members of the State Medical Society, general practitioners as well as specialists were made aware that their presence was welcomed by the management of the Congress.

The Committee is concerned regarding a method for presenting to the members of the Society much of the interesting data which has accumulated over the years of its service, in order to bring home to all those physicians, who are practicing obstetrics in the state, the lessons learned from these maternal death studies. Just what method should be employed depends on the action taken by the House on the committee's recommendation in these respects.

The Committee recommends that a report be made of certain illustrative cases taken from the Maternal Mortality Studies which would be used to point out the dangers to the mother and baby of certain clinical practices in connection with the management of such cases. These would form the basis of a clinical paper on some subject written by a member of the committee and publicized in the State Journal. There would be complete anonymity as regards patients, hospitals and doctors and only the lesson to be learned, would be pointed out by the writer.

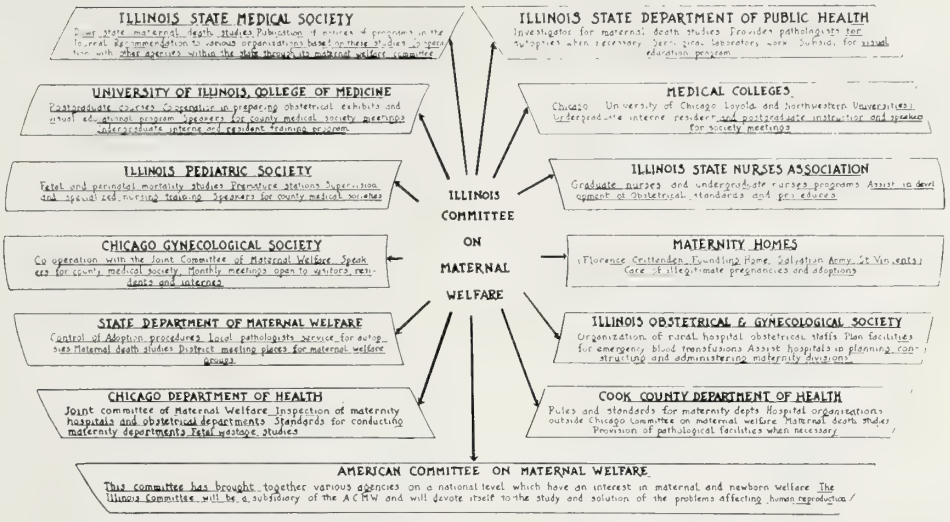
The Committee presented an exhibit at the State Meeting last year showing the results of its maternal death studies. An illuminated plastic map of the State of Illinois was prepared on which were drawn lines indicating the county outlines. Each maternal death occurring in 1953 was recorded on the map in the form of a colored plastic cross. The various colors represented different causes of death. Another panel of the exhibit showed the general set-up of the program of the Sixth American Congress on Obstetrics and Gynecology and indicated that all physicians were invited to participate in the Congress for the ten dollar registration fee whether they were members of the American Committee on Maternal Welfare or not. It was also arranged with the Illinois Academy of General Practice that their members could obtain full time credit for five days on informal credit to meet their educational requirements. This was in the opinion of the Committee, one of the biggest bargains in postgraduate education they ever had offered to them.



There was also the biggest gathering of specialists in the field of obstetrics and gynecology, Doctors, Nurses, Hospital Administrators and Public Health Personnel, ever assembled in the United States. It was jointly sponsored by the American Academy of Obstetrics and Gynecology. Five days packed with the latest information freely discussed, left ample opportunity for the 3,000 participants to get the information from the Congress for which they came with the least amount of time consuming ceremonies.

A third panel of the exhibit set forth a proposed plan for the integration of the various organizations that have a stake in maternal welfare within the State into an Illinois State Maternal Welfare Committee which would be a component part of the American Committee on Maternal Welfare but would deal only with problems in the State. Such a Committee could assist the State Society Committee in its death studies in various ways. Postgraduate courses could be arranged with the University of Illinois; Nurses, Doctors, Public Health Personnel and Hospital Administrators could come together for an annual State Congress in different parts of the State at which controversial subjects could

PROPOSED ORGANIZATION CHART



be taken up and settled or at least compromised until settlement could be brought about. We are sure that the publicity of such a meeting would do much to strengthen our public relations and allow the people to know that their problems are a real challenge to the medical profession which it is deeply conscious of. Their interests also are paramount when trying to solve these problems.

The Illinois Obstetrical and Gynecological Society which the Committee helped to organized five years ago is now a flourishing society of about 100 members who meet three times a year and who are studying their own problems throughout the state and improving the standards of maternal and newborn care rendered by themselves and by other members of the profession (by precept and example) with whom they come in contact.

The chairman of your Committee was asked to represent the American Association of Obstetricians and Gynecologists on a five man American Committee which met with delegates from other countries to form an International Society of Obstetrics and Gynecology at a Congress held in Geneva, Switzerland in late July. The society was formed and will hold its second meeting in Montreal, Canada in 1957.

The Committee wishes to acknowledge the support of the Council in its work and hopes that in the very near future the program in Illinois will be second to none in this country.

Respectfully submitted,

FREDERICK H. FALLS, M. D.
Chairman.
W. C. SCRIVNER, M. D.
Vice-Chairman.

Members:
A. B. OWEN, M. D.
F. J. P. TWOHEY, M. D.
W. R. YOUNG, M. D.
R. R. LOAR, M. D.
MILTON BITTER, M. D.
J. B. WALLER, M. D.
CARL GREENSTEIN, M. D.,
CHARLES E. AHLM, M. D.
J. C. CAREY, M. D.

Alternates:
J. J. MULLEN, M. D.
J. M. COLLINS, M. D.
JOHN SMITH, M. D.
R. N. REDMOND, M. D.
F. J. STEWART, M. D.
C. H. BALL, M. D.
F. X. DEVER, M. D.
V. M. LONG, M. D.
RAY E. BUCHER, M. D.
J. W. TIDWELL, M. D.
J. E. FIELDS, M. D.

Committee on Maternal Welfare.

MEDICAL ECONOMICS

TO THE MEMBERS OF THE HOUSE OF DELEGATES:

Your Medical Economics Committee has just finished an active and profitable year. Our mission, that of publishing one editorial type article in the medical economics section of the Illinois Medical Journal monthly, has been completed.

In August 1954, a dinner meeting of the committee was held at the Hotel Sherman in Chicago. An extensive friendly discussion on the subject of medical economics continued into the night. The committee felt that one of our first duties during the coming year would be to awaken the doctors of Illinois to the recent decision on the fee splitting question by the judicial council of the A.M.A. An article entitled "Ethics and Economics" was published in the October issue.

It was also decided that it would be well to awaken the doctors of our state to the activities of the Council of the State Society in proposing legislation relative to the Coroner's office. Therefore, an article entitled "A Proposed Revision of the Coroner's Act of the State of Illinois" was presented in March of this year.

Attention has been drawn to the activities of the Workmen's Compensation Board in an article—"Is Our Workmen's Compensation System Satisfactory."

An excellent editorial on "General Practice" was written by Bill Fullerton of Sparta. This editorial was not only well received throughout the state but permission to republish it was requested by several state Medical Journals.

The present status of "Nursing Education" was presented in a well timed discussion by Roland Cross, Jr.

Other articles published since our 1954 annual report have included discussions on our Latin American internes and residents, the progress of Illinois Medical Service (Blue Shield), relationship of the Board of Health to the hospital in the responsibility of patient care, health agencies, the evolution of a community health plan, and in December a review of the preceding year.

Subjects being readied for coming issues include union health plans, the Veterans' program, the A.M.A.

educational foundation, and the collection and distribution of money by charitable medical organizations.

The members of the committee have all worked well as a unit and it is a pleasure to present you with this report. We wish to thank Miss Ann Fox and her staff at the Chicago office of the Illinois State Medical Society for their fine contribution to the work of this group.

We also wish to thank Dr. Harold Camp and Dr. Ted Van Dellen for their timely aid and suggestions.

Respectfully submitted,

JOHN R. WOLFF, M. D.
Chairman.
WALTER C. BORNEMEIER, M. D.
EDWARD W. CANNADY, M. D.
ROLAND R. CROSS, JR., M. D.
E. F. DIETRICH, M. D.
W. W. FULLERTON, M. D.
EDWIN F. HIRSCH, M. D.
FREDERIC T. JUNG, M. D.
W. R. MALONEY, M. D.
CAESAR PORTES, M. D.
WILLIAM REQUARTH, M. D.
FREDERICK W. SLOBE, M. D.
Committee on Medical Economics.

MEDICAL HISTORY

TO THE MEMBERS OF THE HOUSE OF DELEGATES:

This Committee was created in 1947. Its assignment was to compile Volume II of the "History of Medical Practice in Illinois." For various reasons, set forth by Dr. Davis in the early pages of the book, the period covered extends from 1850 to 1900—that is, the first fifty years of the Society's existence after its reorganization.

In previous years the Committee has reported progress—sometimes very little progress. Last year we expressed the hope that the book would be off the press by the time the House of Delegates convened in 1955. It seems likely that this hope will be realized. (This report is written in March, and we are told that the book will be ready for shipment May 6). The last of the manuscripts reached Dr. Davis early in the summer of 1954. By August 1 it was evident that the entire manuscript would be ready for the publishers shortly. The Council at its August meeting set up a special Publication Committee consisting of Doctors Vaughn, O'Neill, and Camp ex-officio and Charles P. Blair, Stone, John L. Reichert, Oldfield and Hutton. After considerable investigation the Committee decided that R. R. Donnelley & Sons made the best offer, and the manuscript was turned over to them. Dr. Camp signed the contract with that firm late in October. Dr. Davis had edited and re-edited the manuscript and had read and corrected several chapters of galley proofs before his sudden death December 19, 1954. For this reason the Council did not employ an editor to succeed Dr. Davis. Mrs. Louise B. Searing, to whom we are very much indebted, continued to receive the master proof, and Doctors Vaughn, Norbury, O'Neill, Camp, Charles P. Blair, Stone, Oldfield, Reichert and Hutton received page proofs. Their corrections were forwarded to Mrs. Searing.

At its December meeting the Council set up a Sales Committee composed of the same men who had made up the Publication Committee. The Woman's Auxiliary has generously adopted the sale of the book as one of its projects. The Sales Committee has met a number of times with representatives of the Auxiliary, and it is hoped that plans for distributing this book widely over the state will be put into effect.

Almost from the time of its reorganization the Society, or various of its members, has been interested in medical history. Beginning in 1851 Dr. N. S. Davis wrote the "History of Medical Education," which ran serially in the North West Medical Journal. In 1876 Dr. James Nevins Hyde wrote "Medical Chicago," which ran serially in the same journal and was later published in book form. Early in the 80's the Society set up a Biographical Committee, which was in essence a history committee. Dr. John H. Hollister was made editor-in-chief and in 1889 announced that their material ought to be ready for publication about 1900. Dr. Hollister died before that time and the material was never published. In 1893 the Society ordered Dr. W. O. Ensign of Rutland to write its history for presentation at the next annual meeting. He was ill at that time and the material was never published. In 1895 he reported, as chairman of a special Committee on Medical Societies. This also was not published.

In 1913, on orders of the Council, Dr. Carl E. Black brought out a General Index of the Society's Transactions. One of his reasons for doing this, Dr. Black said, was to stimulate other men to write more detailed histories of medicine. In 1923 the House of Delegates set up a committee to compile a "History of Medical Practice" and in 1927 Volume I was brought out under the editorship of Dr. Zeuch. In view of this long record of interest in medical history, it seems likely that the Society will some time produce Volume III. It can be done more easily, more accurately and more cheaply if a committee is set up at this time to supervise the collection of historical material. County Societies should be urged to send to the Secretary's office each year items of interest that have occurred in their counties. This committee could be small and meet infrequently. Its establishment and operation should cost very little.

The production of Volume II has taken a great deal more time than any one anticipated when the Committee was created. The Committee appreciates the patience and cooperation of the Council without which this work could not have been done. The chairman is particularly grateful to the Council and to every member of the Committee. His contact with them has been extremely pleasant. The entire Society will ever be indebted to the men and women who have contributed chapters to this book. The writing of those chapters represented an enormous expenditure of time and energy, and all of them were produced by people who were already busy.

The Committee had hoped to include a picture of Dr. Davis in the book. He refused permission for this. After his death it was thought that his family might like this as a personal memento, but they also refused permission. At the request of the Committee, Mr. James C. Leary wrote a beautiful tribute to Dr. Davis, which appears in the early pages of the book.

Publication of Volume II would seem to conclude the Committee's work and presumably it will be disbanded. Working with the Committee has been a long, sometimes strenuous, and always a very pleasant task.

Respectfully submitted,

JAMES H. HUTTON, M. D.
Chairman.
JOSIAH J. MOORE, M. D.
DAVID J. DAVIS, M. D.*
E. H. WELD, M. D.
GEORGE COLEMAN, M. D.
JAMES P. SIMONDS, M. D.
CHARLES P. BLAIR, M. D.
TOM KIRKWOOD, M. D.
WILLIAM A. MANN, M. D.
FREDERICK W. MERRIFIELD, M. D.
KELLOGG SPEED, M. D.
ARCHIBALD HOYNE, M. D.
B. BARKER BEESON, M. D.
MISS ELLA SALMONSEN, *Secretary.*
Committee on Medical History.

* *Deceased.*

DR. JAMES H. HUTTON: I have a supplementary report.

Mr. President and Members of the House of Delegates: A year ago we asked you to pray the Council to make funds available to complete the publication of Volume II of the History of Medical Practice in Illinois. Today you see the book completed, and this is a copy of it. We had a rather difficult time. It looked as though we would not get it out in time for the meeting. The Editor, Dr. D. J. Davis, died December 18, and Jim Leary wrote one of the most beautiful tributes I ever read; then he died on April 12 of the same disease that took Dr. Davis. Then the printers informed us that if the proof could be read and the index made, they could finish the book in time for the meeting. So Miss Salmonsen and Mrs. Searing were asked to take over. They had never indexed a book having to do with medicine but they spent a great deal of time and with great difficulty completed it by the alloted date, and shipped it to Crawfordsville. It was brought back into Chicago on the morning of Friday, May 13.

We think this book has great public relations value if distributed widely. It has a good deal of interest for research, particularly for ministers who often talk about other things than theology. We think it ought to be in every library in the state and in every medical library in the United States.

The Woman's Auxiliary has made the sale of this book one of their projects. At this time I would like to introduce some members of the Woman's Auxiliary.

It has been suggested also that only old men are interested in medical history. Through the kindness of Dr. H. Close Hesseltine we have persuaded Dr. Ilza Veith, Assistant Professor of Medicine and History at the University of Chicago to take two or three minutes to tell us about the place of medical history in the curriculum. I will ask Dr. Hesseltine to escort Dr. Veith to the rostrum.

DR. ILZA VEITH: Dr. Vaughn, Ladies and Gentlemen: Thank you very much for your applause. As Dr. Hutton has said, it has often been stated that medical history is for elderly and retired physicians only. I was asked to tell you in three minutes why young men should study medical history. Actually, it is astounding that it is a question why the physician should want to study it at all. I cannot imagine how any one can be successful in his profession if he does not know how his profession was developed, how it came to occupy the place it does. History has been studied by artists, musicians, and numerous others. In the last century the study of medical history has been lost. It is a very important subject. By knowing the history of their profession through which some knowledge of humanities and social sciences have come a little closer, we have a better knowledge of the development of medicine. Medical history is also of interest to the physician who is no longer physically active. It is impossible to become expert all of a sudden at something without some appreciation of its beginning. I would like to close these few remarks with a story that happened to my teacher at Hopkins. He was asked by an obstetrician who was then about 65, what three or four books Dr. Cederhurst would recommend to him, so he could become a medical historian. He replied, "I can recommend a number of titles to you, but I am going to be retired soon and what three books could you recommend so I can become an obstretrician?"

DR. HUTTON: Thank you Dr. Veith. The Woman's Auxiliary has graciously agreed to undertake the sale of this book. I would like to introduce Mrs. Houda, Mrs. Hoeltgen, Mrs. Young, Mrs. Kwedar, the President, and Mrs. McDonnough.

This book can sell itself. Medical societies do not do too much with medical history. It is not too long since Colorado got its first grievance committee and the news was spread all over the front page of the newspapers. The Illinois State Medical Society had a grievance committee 136 years ago. We hope you will visit our booth in the Exhibit hall and leave an order. Thank you very much.

MENTAL HEALTH

To the Members of The House of Delegates:

The Committee on Mental Health had one meeting September 18, 1954 at the time of the A.M.A. Conference of its committee with those of the various state societies. Dr. Baer, Dr. Levinson and the Chairman made up the group present. By reason of illness neither Dr. Ellis nor Dr. Hawkinson have been able to be active. In order to further the work of the Committee the Council approved the appointment of the following additional members:

Dr. Harry Phillips, East St. Louis.

Dr. John L. Reichert, Chicago.

Dr. Murray E. Rolens, Springfield.

Although no further meetings have been held to date it is hoped to have one at the time of the Annual Meeting. Informal correspondence and conversations have been held with most of the members.

Statewide distribution of the Psychiatric Bulletin by the Illinois Department of Public Welfare in conjunction with the Illinois Society for Mental Health met with Council approval on the committee's recommendation.

The committee recommended and the Council concurred in having the statement "Approved by the Illinois State Medical Society" printed on the pamphlets "You and Your Child" now in process of publication for the Illinois Department of Public Welfare.

One of the activities, which has largely been that of voluminous correspondence and personal conferences, has been in relation to the proposed legislation for certification of clinical psychologists, desired by the Illinois Psychological Association. Drafts and redrafts of bills with comments of various types have traveled back and forth. Walter Oblinger, Associate Counsel of the State Society, has given freely of his time and knowledge in evaluating the proposals so that the views of organized medicine in Illinois could be presented on this subject. The proposed legislation is still in an uncertain status as regards actual introduction. A supplementary report at the time of the Annual Meeting may be necessary.

Inquiry was received from the Texas State Medical Society regarding activities in Illinois for retarded children. It is recommended that this phase of mental health receive further study with reference to the Special Education Schools in the school system, the Division of Vocational Rehabilitation and the Illinois State Schools at Lincoln and Dixon.

Alcoholism as a special phase has been discussed with the Department of Public Welfare and Portal House. The Winnebago County Society's interest in this as a part of Mental Health is commendable.

Mental Health Week will have come and gone by the time of the presentation of this report. The State Society again acted as a Co-sponsor in this effort to make more citizens of our state aware of the importance of mental health.

Illinois, with the fourth largest Medical Society in the country, should be in the forefront of the survey proposed by President Eisenhower of mental health resources and needs in our country. While definitely standing for individual and professional autonomy we would be negligent indeed if we did not further, in a constructive manner, an approach to the Nation's number one health problem. A group of illnesses that account for over half the daily bed occupancy of hospitals in this country cannot, must not, be passed by. A year ago the report of this committee referred to forty-

seven thousand citizens of Illinois in hospitals by reason of mental illness. This year the number is fifty thousand. It is strongly recommended that the Illinois State Medical Society assist this program in every way in our own state.

This report, written by the Chairman, seems to him quite inconsiderable and quite innocuous, almost negative in fact. Yet it does appear to him that there is a broader interest over the state developing in this phase of medicine which means so much to our patients, our communities, our state, our nation. The committee members have been most helpful.

Respectfully submitted.

F. Garm Norbury, M. D.
Chairman.
Walter H. Baer, M. D.
C. C. Ellis, M. D.
Oscar Hawkinson, M. D.
Abraham Levinson, M. D.
Harry Phillips, M. D.
John L. Reichert, M. D.
Murray E. Rolens, M. D.
Committee on Mental Health.

MILITARY AFFAIRS AND EMERGENCY MEDICAL SERVICE—CIVIL DEFENSE

To the Members of The House of Delegates:

There has been no appreciable change in the implementation of the health services program in Illinois during the past year except for the development of plans for securing of equipment to deal with the natural local disasters in several areas of the state. However, the event of the hydrogen bomb has increased the interest and concern in civil defense problems especially in the health service field.

The Illinois Civil Defense Agency in December, 1954 distributed a hydrogen bomb Fact Sheet which provides a sound base for civil defense planning in this field.

With the release of more information regarding the hydrogen bomb, planning the problem of pre-attack dispersal of populations in metropolitan areas is beginning to receive major attention and some sound planning is beginning to evolve.

Paralleling the planned dispersal, the problem of mutual aid activity in counties and cities surrounding metropolitan target areas is receiving greater attention. The volume of the dispersal problem is such that counties and cities which may be involved in caring for a large volume of displaced persons should reconsider their mutual aid plans and become prepared for much greater activity in this respect than previously anticipated.

The problem exerting the greatest impact in the civil defense field this year is the one of radioactive "fallout." This became evident as a major problem following the hydrogen bomb test in the Pacific Ocean in March, 1954. This brought into proper focus a problem which can affect each county within the state, creating an area of great danger to the health of the population in areas as large as forty miles wide and 150 miles in length. Plans are under way to provide proper radiological monitoring in these areas as they develop and to thus provide information throughout the state which can save many lives.

The Chicago Civil Defense Corps has recently taken action to begin the implementation of the Chicago portion of the basic state plan for the utilization of improvised hospitals and first aid stations. Appreciable progress in this development should soon be evident. The Council of the Chicago Medical Society, at its April, 1955 meeting recommended that the Chicago Civil Defense Corps employ a full time medical director and staff to implement the activation and development of its health services program.

A civil defense immunization program of statewide volume was initiated by the issuance of a proclamation by Governor Stratton in March, 1955 declaring the month of April, 1955 as "Civil Defense Immunization Month" for all voluntary civil defense workers against smallpox, typhoid fever and tetanus. Preliminary information would indicate that this program has widespread interest and that, in addition to providing immunization for civil defense workers, it can be of assistance to the over all Illinois immunization program as advised by the State Board of Health.

There has been no meeting of the Committee this year although several matters have been handled by mail.

Respectfully submitted,

Earl H. Blair, M. D.
Chairman.
C. L. Carter, M. D.
Kenneth H. Schnepp, M. D.
Roland R. Cross, M. D.
Leo P. A. Sweeney, M. D.
Philip Lewin, M. D.
Gilbert Edwards, M. D.

NECROLOGY

To the Members of The House of Delegates:

The Committee on Necrology did not meet during the current year, nor did the committee submit a report, due to the serious illness of two of the three members of the committee. This report, therefore, has been prepared by the Secretary's office.

The deaths of the members listed at the close of this report are those whose deaths have been reported since the 1954 annual meeting. Many of them died before that time, but information concerning their deaths was not received in the Secretary's office until too late for publication in the 1954 Handbook. Unfortunately many county society secretaries are negligent in reporting deaths.

The Society as a whole will feel keenly the loss of many prominent members, but perhaps the greatest personal loss was felt by the councilors and employees of the Society in the loss of Councilor Joseph Lundholm of Rockford, Councilor of the First District, and Mr. James C. Leary, Public Relations Director. Information concerning Councilor Lundholm is included in this report. Jim, as Mr. Leary was known to his many friends in the Society, passed away suddenly on April 12, while attending a meeting of the Council of the Chicago Medical Society. Jim had faithfully served the society since 1945, and prior to that time was a science writer for the Chicago Daily News.

This is the third annual report of the Committee on Necrology, as the committee was not created by the House of Delegates until the 1952 annual meeting.

In compiling the list of deceased members, which follows this report, the Secretary's office has referred to obituaries appearing in Illinois newspapers, the Illinois Medical Journal, the Journal of the American Medical Association, as well as the reports received from county medical society secretaries.

Respectfully submitted,

Secretary's Office, Illinois State Medical Society, for The Committee on Necrology.
Robert H. Hayes, M. D.
Chairman.
E. H. Weld, M. D.
Oscar Hawkinson, M. D.

Appelle, C. George, Champaign, died August 23, 1954. Dr. Appelle was a past president of the Champaign County Medical Society, and also a secretary.

Ascher, John A., Freeport, died May, 1954. Dr. Ascher was a Past President of the Champaign County Medical Society, and was a member of the House of Delegates of the A.M.A in 1918.

Baer, Joseph L., Chicago, died December 8, 1954. Dr. Baer was senior attending obstetrician and gynecologist in Michael Reese Hospital, professor emeritus of Rush Medical School, former president of the American and Chicago Gynecological societies, and former president of the Institute of Medicine of Chicago. He was also on the board of governors of the American College of Surgeons.

Baker, Charles W., Torrance, California, died Dec. 19, 1954.
Bauer, John A., Germantown, died July 15, 1954.
Beck, Viola B., Oakland, died June 4, 1954.
Berkowitz, Charles, Chicago, died January 11, 1954.
Blier, Zachary A., Highland Park, died November 3, 1954.
Blodgett, Pliny R., Chicago Heights, died Dec. 20, 1954. Doctor Blodgett was a past president of the Illinois Academy of General Practice, and was a member of the Medico-Legal Committee of the Illinois State Medical Society at the time of his death. He formerly served on the Committee on Constitution and By-Laws of this Society.
Boulton, Stanton S Towanda, died October 26, 1954.
Branyan, Hugo, Waukegan, died October 24, 1954. Dr. Branyan was a Past President of the Lake County Medical Society.
Bressmer, Walter A., Blue Mound, died April 12, 1954.
Brown, Ralph C., Winnetka, died August 31, 1954. Dr. Brown was Rush professor emeritus of Medicine at the University of Illinois College of Medicine.
Bucher, Clarence S., Champaign, died August 23, 1954.
Butner, Andrew J., Harrisburg, died March 7, 1955.
Campbell, Robert K., Springfield, died 1954.
Cantle, Herbert C., Cropsey, died October 13, 1954.
Carr, James G., Evanston, died October 17, 1954. Dr. Carr was emeritus professor of Medicine at Nothwestern University Medical School, former chief of the medical staff of Evanston Hospital. He received the distinguished service award of the Mississippi Valley Medical Association in 1939, and was a founder and president of the Chicago Heart Society.
Chandler, Fremont A., Chicago, died December 22, 1954. Dr. Chandler was Chairman of the Department of Orthopedic Surgery at the University of Illinois College of Medicine and Senior Attending Orthopedic Surgeon at St. Luke's Hospital.
Chandler, Harriet Day, Decatur, died December 3, 1954. Dr. Chandler was a charter member of the Business and Professional Woman's Club.
Chittum, Jason D., Sorento, died March 12, 1955.
Clark, Samuel N., Jacksonville, died May 3, 1954.
Cochran, Earl R., Rockton, died August 27, 1954.
Cohen, Mandel A. I., Chicago, died February 27, 1955.
Cook, Franklin, Evanston, died August 8, 1952.
Corbus, Budd C., Evanston, died November 7, 1954.
Costenbader, Clinton F., Chicago, died May 16, 1954.
Cox, Elwood Hunter, Mt. Pulaski, died February 26, 1954.
Dame, Louis P., Rockford, died 1954.
Davies, Raymond E., Spring Valley, died April 19, 1955. Dr. Davies served as Secretary of the Bureau County Medical Society for many years.
Davis, David J., Wilmette, died December 19, 1954. Dr. Davis was Dean Emeritus of the University of Illinois College of Medicine. He was permanent historian of the Illinois State Medical Society and was Editor of the Second Volume of the History of Medicine in Illinois, which he completed shortly before his death.
Davis, Edward, Belvidere, died June 19, 1954.
DeBere, Clement J., Wilmette, died March 11, 1954. Dr. DeBere was a Past President of the American Proctologic Association.
Denny, Alden R., Griggsville, died February 1955.
Diller, Francis S., Rantoul, died November 14, 1953.
Doepp, Edward, Blue Island, died November 28, 1954.
Dorman, Henry P., Chicago, died December 13, 1954.
Dougherty, Leslie D., Cowden, died November 21, 1954.
Douglass, Thomas C., Evanston, died October 9, 1954.
Easton, Milo T., Peoria, died April, 1955.
Egan, Edward M., Chicago, died January 4, 1955. Dr. Egan was a Past President of the South Shore Branch of the Chicago Medical Society.
Egdahl, Anfin, Rockford, died July, 1954. Dr. Egdahl was a Past President of the Winnebago County Medical Society.
Enos, Edward W., Alton, died September 27, 1954.
Evans, Raymond, Champaign, died February 1, 1954.
Fenyes, George, Kankakee, died June 27, 1954.
Finley, George W., Plano, died October 2, 1954.
Fish, William O., Fillmore, died March 28, 1955.
Fischmann, Egon W., died June 13, 1954. Dr. Fischmann was Chairman of the Department of Obstetrics and Gynecology at the Chicago Medical School.
Froehlich, Alex L., McHenry, died April 17, 1954.
Frolick, Robert G., Quincy, died August 4, 1954.
Fuller, Erlan G., Gardner, died February 19, 1954.
Gerard, Margaret W., Chicago, died January 12, 1954. Dr. Gerard was internationally known as a child psychiatrist. She became professor of psychiatry at the University of Chicago in 1927.
Gereb, Louis, Maywood, died September 6, 1954.
Geymer, George C., Chicago, died April 14, 1954.
Goebel, Gustavus A., Chicago, died September 9, 1954.
Golub, H. William, Chicago, died December 24, 1954.
Gould, Harold V., Chicago, died February 22, 1955.
Greaves, Joseph A., Chicago, died April 18, 1954.
Griffiths, Evan H. M., Chicago, died January 27, 1955.
Guertin, Joseph A., Kankakee, died September 18, 1954.
Guy, John M., Danville, died June, 1954.
Hammitt, Frank C., Peoria, died October 1, 1954.
Healy, M. Edward, Chicago, died May 9, 1954.
Hecht, M. Charles, Wilmette, died September 23, 1954.
Herzberg, Kurt, Skokie, died October, 1952.
Hess, A. Philip, Chicago, died April 23, 1954.
Hill, Frank A., Ormond, Florida, died March 10, 1952.
Hill, Lewis R., LaGrange, died December 15, 1954.
Hoag, Howard C., Waukegan, died March 25, 1954. Dr. Hoag was a Past President of the Lake County Medical Society.
Hoeffel, Adelaide D., Chicago, died January 19, 1954.
Holloway, Howard J., Evanston, died October 6, 1954.
Hoyt, Lee T., Roseville, died June 16, 1954. In 1948 Dr. Hoyt was elected the Outstanding General Practitioner by the Illinois State Medical Society. Dr. Hoyt had served as Chairman of the Committee on Nutrition of this Society.
Humel, Richard J., Riverside, died February 25, 1954.
Hunter, Archibald H., Staunton, died 1954.
Hutcheson, Bellenden S., Cairo, died April 9, 1954.
Hutchins, Linda K., Shannon, died December 31, 1954.
Irvin, Cyrus H., Champaign, died February 1955.
Irwin, James R., Springfield, died January 21, 1955.
Jackson, Edward L., Maywood, died June 14, 1954.
Jacobs, Charles M., Winnetka, died September 11, 1954.
Jacobs, Merrill R., Chicago, died February 27, 1955.
Jones, Thomas G., Chicago, died April 7, 1954.
Kane, William W., Pinckneyville, died March, 1955.
Kaplan, Leo A., Chicago, died February 20, 1954.
King, Ralph, Olney, died February 26, 1954.
Kloster, Grant M., Oregon, died November 12, 1954.
Knappenberger, George E., Macomb, died October 23, 1954.
Knappenberger, T. Gaillard, Champaign, died September 14, 1954. At the time of his death, Doctor Knappenberger was a member of the Grievance Committee of this Society.
Knoop, William, Chesterfield, died July 6, 1954.
Koff, Arthur K., Chicago, died June 28, 1954.
Kraus, John E., Peoria, died January 17, 1955.
Lamb, James G., Cerro Gordo, died December 9, 1954.
Lambert, John V., Chicago, died April 11, 1955.
Landis, Clyde R., Chicago, died December 23, 1954.
LaReau, Hestor G., Chicago, died March 4, 1954.
LeBlanc, Florimond J., Elgin, died March 7, 1955.
Lescher, Edwin R., Elgin, died November 9, 1954.
Lester, Rollin H., Morrison, died March 1, 1955.
Levinson, Sidney O., Chicago, died June 20, 1954. Dr. Levinson was Executive Director of Michael Reese Research Foundation since 1940. At the time of his death he was serving on the Committee on Blood Banks of this Society.
Lewis, George C., Danville, died September 16, 1954.
Lifschutz, Jacob D., Chicago, died March 31, 1954.
Lindsey, Lucien N., Forsyth, died April 8, 1955.
Lorenz, Matthias E., Chicago, died October 6, 1954.
Low, Abraham, Evanston, died November 17, 1954.
Lowth, Robert J., Chicago, died October 24, 1954.
Lundholm, Joseph S., Rockford, died October 7, 1954. Dr. Lundholm was Councilor of the First District, Illinois State Medical Society, at the time of his death. He was a Past President of the Winnebago County Medical Society, and had served as Vice President of the Illinois State Medical Society. Dr. Lundholm was a well known surgeon. At the time of his death he was serving on the Committee on Cancer Control and the Committee on Voluntary Plans for Medical and Surgical Care of this Society.
McCarthy, David H., Springfield, died March 27, 1955.
McCaughey, Robert S., Danville, died August 9, 1954. Dr. McCaughey was a Past President of the Vermilion County Medical Society.
McCleery, Thomas S., Hazelcrest, died July 26, 1954.
McKee, John F., Johnston City, died 1954.
McLaughlin, James H., Chicago, died March, 1952.
Mayes, Corwin S., Springfield, died January 11, 1955. Dr. Mayes was formerly a Vice President of the Illinois State Medical Society and a President of the Sangamon County Medical Society.
Meisenheimer, Harold O., Arlington Heights, died March 6, 1955.
Melaik, Hattie B., San Francisco, California, died October 10, 1954.
Meloy, Earl S., Highland, died March 5, 1954.
Mershimer, William C., Shawneetown, died January 29, 1955.
Miller, John E., Quincy, died April 5, 1955.
Minter, Paul E., Wilmette, died September 26, 1954.
Montgomery, Edmund, Quincy, died December 8, 1954. Dr. Montgomery was recognized as the oldest practitioner in the United States. He was on duty at his office in his home until a few days before his death when he suffered a heart attack at the age of 96, after 76 years in practice. He was a charter member of the American College of Surgeons.
Moore, Carlyle, Vandalia, died July 22, 1954.
Moore, Ernest S., Pasadena, California, died February 18, 1953.
Muller, Fred H., Chicago, died November 23, 1954. Dr. Muller was a Past President of the Chicago Medical Society and had served as Vice President of the Illinois State Medical Society several times. He had also served as a delegate from this Society to the House of Delegates of the American Medical Association, and was a member of the Committee on Nursing of this Society at the time of his death.
Murphy, John C., Ridgway, died March 12, 1955. Dr. Murphy was a Past President and Secretary of the Gallatin County Medical Society.
Nady, Andrew, Fort Bayard, New Mexico, died September, 1952.
Nelson, Ole C., Oak Park, died January 16, 1954. Dr. Nelson was formerly Medical Director of Cook County Hospital, and was widely known as a physician and administrator.

Nyman, Carl V., Rockford, died October 20, 1954.

Ochsner, Ernest E., Rockford, died November 4, 1954. Dr. Ochsner was a Past President of the Winnebago County Medical Society.

O'Neil, Dillon G., Chicago, died July 31, 1954.

Oppenheimer, Leo, Wilmette, died November 24, 1954.

Ormsby, Oliver S., Glencoe, died April 9, 1954. Dr. Ormsby was formerly Professor of Dermatology at the University of Illinois College of Medicine.

Parks, Jennie W., Glendale, Arizona, died October, 1954.

Parmley, Joseph G., Marion, died April 15, 1954. Dr. Parmley had served the Williamson County Medical Society as Secretary for 18 years and as President for four years.

Parowski, Stanislaus, Chicago, died March 15, 1954.

Pessl, Paul D., Chicago, died August 19, 1954.

Peterson, Ralph O., Chicago, died April 25, 1954.

Phillips, John H., Granite City, died June 10, 1954.

Proby, Edmund A., Chicago, died October 12, 1954.

Pusch, Jerry B., Chicago, died January 22, 1955.

Quay, Russell A., Stanford, died January 3, 1954.

Randell, Harold E., Chicago, died January 15, 1954.

Rettig, Frederick A., Chicago, died December 13, 1954. Dr. Rettig was the founder of the Alexian Brothers Hospital Foundation.

Reuss, Harry P., Granite City, died October 9, 1954.

Ryan, Thomas E., Ransom, died 1954. Dr. Ryan was a Past President of the LaSalle County Medical Society.

Rynne, James P., Chicago, died September 29, 1954.

Sala, Roland O., Rock Island, died August 19, 1954. Dr. Sala was a Past President of the Rock Island County Medical Society.

Sasko, Martin P., Chicago, died March 6, 1954.

Sawyer, Charles F., Twin Falls, Idaho, died August 11, 1953.

Schroeder, George H., River Forest, died April 25, 1954.

Schneider, Leo E., Oregon, died 1955.

Schoen, William P., Chicago, died February 4, 1954.

Scott, David R., Chicago, died February 5, 1954.

Scott, Raymond G., Geneva, died December 8, 1954. Dr. Scott was a Past President of the Kane County Medical Society.

Seelye, Norman L., Harvard, died February 19, 1954.

Seidel, Albert W., Park Ridge, died April 3, 1955.

Shacter, Joseph A., Chicago, died November 25, 1954.

Shafer, Harry L., Cornell, died November 11, 1954. Dr. Shafer was a Past President of the Livingston County Medical Society.

Sheets, Raymond F., Carthage, died 1954. Dr. Sheets was a Past President of the Hancock County Medical Society.

Spiesman, Irwin G., Maywood, died September 11, 1954.

Spitze, Edward C., Champaign, died January, 1955.

Statler, Oliver I., Huntley, died April 20, 1954.

Sterbini, Domenico A., Colfax, died 1954.

Stewart, Robert H., Galva, died May 6, 1954. Dr. Stewart was a Past President of the Henry County Medical Society.

Strauss, Jerome F., Chicago, died May 24, 1954.

Summers, Edmund, Mattoon, died August 7, 1954.

Tamari, Marvin J., Chicago, died October 11, 1954.

Taylor, Arthur C., Chicago, died March 29, 1955. Dr. Taylor was Chairman of the Ethical Relations Committee of the Illinois State Medical Society at the time of his death.

Terrell, Alexander B., Chicago, died December 4, 1953.

Thompson, Leonard M., Lena, died March 22, 1954.

Ursich, Joseph E., LaGrange, died September 24, 1954.

Viskocil, Emil J., Lockport, died April 26, 1954. Dr. Viskocil was a Past President of the Will-Grundy County Medical Society.

Waters, Philip S., Bethalto, died October 8, 1954.

Wedel, Gustave F. L., Chicago, died May 10, 1954.

Weiss, Sol A., Chicago, died January 21, 1954.

Wellenreiter, Otto F., Danville, died June 14, 1954.

West, Hugh H., Elgin, died August 31, 1954.

Williams, Everett B., Chicago, died March 17, 1954.

Williams, William W., Quincy, died February 12, 1955.

Wolford, Arthur F., Chicago, died February 21, 1954.

Wong, Gene Sen, Chicago, died November 13, 1954.

Yeakel, William K., Des Moines, Washington, died December 27, 1954.

Ziegler, John H., Farmer City, died January 21, 1954.

Zobrist, Benjamin F., Assumption, died September 7, 1954. Dr Zobrist was a Past President of the Christian County Medical Society.

Zorger, Annie L., Waynesville, died May 28, 1954.

THE SECRETARY: The Chairman of the Committee on Necrology was ill and one of the assistants in the office at Monmouth made up the report from the list of physicians who have passed away since the last annual meeting. I think it would be in order to stand for a minute in memory of those who have passed away.

President Vaughn asked for a rising moment of silence.

(The House stood in silence for one minute)

NUTRITION

To the Members of The House of Delegates:

The first meeting of the present Committee on Nutrition of the Illinois State Medical Society was held on June 30th, 1954, at the Conrad Hilton Hotel, Chicago. In attendance at the meeting were the following members: Drs. John J. Miller, Harry Mantz, Warner Newcomb, and the chairman of the Committee, Dr. Paul A. Dailey. In addition to members were Mr. James C. Leary, Director of Public Relations, Illinois State Medical Society; Dr. James R. Wilson, Council on Foods and Nutrition, American Medical Association; Dr. Jonathan Forman, Louis Bromfield and Ollie Fink, all officers of Friends of The Land. This meeting was held in conjunction with the 13th Annual Institute on Conservation, Nutrition and Health of the Friends of The Land.

Among the various topics discussed at this meeting were the dangers to the public of self medication on low sodium diets. It was moved, seconded and voted unanimously that a warning should be issued to the public by the Committee on Nutrition. Secondly, a resolution setting forth the fine work of the late chairman of the Committee on Nutrition, Dr. Lee Hoyt, was passed. Next was considered the advisability of sponsoring diets to be made available to the physicians which would enable them to have for patients a specific diet for specific disease. Dr. Harry Mantz was appointed to look into this particular endeavor.

The members of the Friends of The Land invited the Committee on Nutrition to sponsor the first day of the meetings of the 14th Annual Institute on Soil, Foods and Health to be held in Chicago in June 27th, 28th and 29th, 1955. The meeting of the Committee was then adjourned.

In order to promote a program sponsored by the Committee on Nutrition and to be given on June 27th, 1955, the chairman spent a day with Dr. Jonathan Forman in Columbus, Ohio, at which time a tentative outline was made embodying this meeting. The first day is to be entitled *Feeding the Sick*. Most of the speakers for the first day of the meeting are being supplied through the efforts of the Committee on Postgraduate Training, Dr. Louis R. Limarzi, Chairman. The complete program should be ready by the time this report is read by the reference committee.

On September 20th the Chairman conferred with Dr. Limarzi and Dr. James R. Wilson. Dr. Limarzi assured me that the Scientific Service Committee would support the program and be happy to furnish speakers. Dr. Wilson assured me that the Council on Foods and Nutrition would support the project in every possible way, not only by supplying speakers but also by supplying A.M.A. exhibits on Nutrition and by giving the meeting publicity.

A meeting of the Committee on Nutrition was held in St. Louis on October 19th, attended by Committee Members, Newcomb, Mantz and Dailey with Dr. James R. Wilson as guest, unanimously voted to present this proposal to the Council of the Illinois State Medical Society for approval.

The next order of business was the unanimous approval of the acceptance of a resolution concerning the Food Acceptance Program of the Council on Foods and Nutrition. This resolution is as follows:

A Statement and a Resolution Concerning the Food Acceptance Program of the Council on Foods and Nutrition of the American Medical Association

Visible evidence of one of the services performed by an organized profession, medicine, in the interest of the public, is the Seal of the Council on Foods and Nutrition of the American Medical Association.

Twenty-five years ago a far-sighted Board of Trustees of the A.M.A. recognized the need for the

organization of an authoritative body to answer questions concerning food quality, food needs, nutrition and advertising claims.

What is the Council? How does it work? And, whom does it serve? It is composed of a group of twelve members selected for their knowledge of nutrition, foods and health. They are men and women who have made distinctive contributions in this field. To assist them and facilitate Council work a headquarters staff is maintained. No charges are made for the services of the Council.

The value of the Council's services lies in the scientific knowledge and integrity of these men and women and in their ability to render unbiased decisions based on scientific evidence or on the best available, medical and nutritional opinion.

Under this program the Council considers foods voluntarily submitted by the food processor. He submits samples and pertinent data relative to ingredients, composition and processing methods, as well as representative advertising matter to be used in promotion. The Council then investigates these items in the light of scientific knowledge or authoritative medical opinion. If the food is considered to be wholesome and if the nutritional claims are based upon scientific data, and are honestly presented in the advertising, the product may then be granted the right to display the Seal. When the Council grants the use of its Seal, it is *always* without charge or obligation explicit or implied.

The Council's Food Acceptance Program has served the practitioner of medicine since 1929. It has served even better since 1943 when the Council altered its scope to concentrate more fully on "special purpose foods." These are food of therapeutic value or foods promoted for special groups of population such as infants, invalids, and convalescents. The busy physician does not have time to investigate every product he might wish to suggest for his patient's use. He has come to look for the Council's opinion as he knows that he may confidently prescribe a product bearing the Seal. To him the Seal means that the product is believed by the Council to be wholesome, properly formulated and prepared; and that it is advertised in an adequately informative and honest manner.

The Food Acceptance Program serves the processors of foods. They look upon the Council, not as a policeman, but rather as a trained scientific interpreter of the food needs of people. The Council works with food processors in mutual trust and respect for the improvement of the nutritional standards of foods. It encourages self control, honesty and integrity in industry—essential in a democracy. The Council has served as advisor to many food industries, assisting them in the development of improved foods for the public—our patients. Furthermore, it has successfully promoted improved standards of food advertising and has given guidance in this field.

The Council serves the consumer. The Council's Seal has become a widely recognized hallmark. It assures our patients, even though they may not be familiar with details of Council work, that an independent group of scientists have confidence in the food which bears the Seal. The Seal, at the same time, is a constant reminder of the profession's interest in the public welfare.

* * * * *

With these facts in mind, then, Be It Resolved that the Council on Foods and Nutrition be commended for its fine work in the past, and further, that it be encouraged by the American Medical Association to continue the use of its Seal and to strengthen its Acceptance Program.

As of this date the plans for the program of the Friends of The Land are progressing nicely. As soon as all of the various endeavors are tied up in the official program it will become a part of this report. A meeting is planned for April 24th by the Committee on Nutrition. To this meeting will be invited representatives of the Friends of The Land to make final plans for the Institute in June.

I have here a copy of the release on Warning Relative to Low Salt Diets.

"The Committee on Nutrition of the Illinois State Medical Society finds it necessary, as a public service, to sound an emphatic warning against the current fad for the so-called "salt-free," "Salt-poor" or "low-sodium" diet, when undertaken on the basis of self-diagnosis and self-administration.

No individual should attempt to maintain such a diet except under close, constant supervision by a physician. It is dangerous to disturb the salt balance of the body.

The only persons who might be benefited by such a diet are those seriously ill of heart or kidney disease, who should therefore be under the constant care of a physician.

This danger is especially menacing in hot weather. The increased loss of salt through excessive sweating in summer heat can cause a severe reaction, which might even be fatal, in a person whose salt or sodium reserve is already depleted by an unsupervised low-salt diet.

Any person who succumbs to the popular fad in the hope of losing weight or reducing blood pressure may be sadly disappointed, since the effect of sodium restriction is largely the loss of water, not tissue, from the body. The water is quickly replaced because of the resultant thirst.

Sodium and chlorine are elements which are essential to normal body function. Every cell in the body requires sodium in some way; a proper balance among sodium, potassium and calcium, for instance, is essential to normal heart action. Chlorine is also required for health; for instance, an adequate supply permits the body to manufacture hydrochloric acid, a component of the gastric juice which is necessary to digestion.

The usual American gets much of his daily requirements of these two elements from his meals, but part of it is taken in the form of extra table salt, which chemically is sodium chloride.

Moreover, in areas such as the Great Lakes basin, the soil is deficient in iodine, which is essential to proper function of the thyroid gland. Iodine is usually added to table salt sold here in order to prevent that type of goiter which is due to lack of iodine.

When table salt is removed from the diet of the citizen of Illinois, therefore, he or she may be dangerously deprived of these three elements essential to life —sodium, chlorine and iodine.

Thus there is a great deal of risk in the low-sodium or salt-poor diet.

Occasionally a physician will take that risk in order to relieve the symptoms of certain patients suffering from heart or kidney disease. In congestive heart failure, for instance, water can accumulate in the tissues, a condition known as edema or, popularly, "dropsy." That imposes a tremendous extra strain on the already weakened heart, so the physician tries to release much of the water, by reducing the intake of sodium, which tends to hold water in the body.

This is a calculated risk, taken deliberately in order to relieve a more immediately dangerous condition. The patient must be constantly watched to see that his sodium reserve does not drop below the minimum essential to health, even to life.

The physician must also be ready to increase the sodium intake immediately in case of any sudden additional loss of sodium, such as that due to prolonged heat and excessive sweating. Perspiration contains sodium chloride and the loss of the chemical via the sweat

glands can be severe. That may occur even in normal persons exposed to extreme heat—with weakness, nausea, cramps, collapse, coma and even death ensuing, unless the sodium deficiency is quickly corrected.

It is clear, therefore, that anyone subjecting himself or herself to a low-sodium diet, on his own initiative and without medical supervision, may invite disaster.

SUMMARY: *Low-sodium diets without medical direction are*

(1) *dangerous to life and health, and*

(2) *largely futile, since little or no fatty tissue is lost.*

CONCLUSION: *Don't do it, unless your physician orders it.*

PAUL A. DAILEY, M. D.
Chairman.
HARRY MANTZ, M. D.
G. C. OTRICH, M. D.
WARNER H. NEWCOMB, M. D.
JOHN P. O'NEIL, M. D.
JOHN J. MILLER, M. D.
Committee on Nutrition.

NURSING

TO THE MEMBERS OF THE HOUSE OF DELEGATES:

Your committee suffered a great loss through the death of Dr. Fred H. Muller. He had been very active as a member of the Advisory Committee to the Nursing Aide Project.

NURSING AIDE PROJECT

The Nursing Aide In-Service Training Project was designed to help hospitals develop on the job training programs for untrained or inadequately trained nursing personnel. A professional nurse was employed by the Illinois Department of Public Health to act as a teacher-trainer in workshops at various parts of the state. At these workshops the instructors from nearby hospitals gather and learn the methods of instructing nursing aides in their own hospitals.

On Aug. 5-6, 1954 a pilot workshop was held in Springfield with ten hospitals participating from District Eight of the Illinois Hospital Association. To-date ten workshops have been held in Illinois. Two day programs were presented at: Springfield, Elgin, Marion, Aurora, Mt. Vernon, Danville, LaSalle, Joliet, and Lawrenceville; and a five day workshop at Chicago. Fifty-eight hospitals participated in the two day programs.

PRACTICAL NURSING

At present the following schools are approved by the State of Illinois:

1. Chicago Public Schools Practical Nursing Program.
   1. Flower Branch.
   2. Greeley Branch.
   3. Princeton Branch.
2. Decatur School of Practical Nursing.
3. East St. Louis School District 189, School of Practical Nursing.
4. Alton, F. W. Olin Vocational School of Practical Nursing.
5. LaSalle, St. Mary's Hospital.

A booklet titled "Approved Schools of Practical Nursing" listing the schools accredited by the National Association for Practical Nurse Education and State Authority was published in January, 1955.

PROFESSIONAL NURSE (R. N.)

The 1954 admission figures are good. In 1953 the 80 schools in Illinois admitted 2,809 students, while in 1954 the 79 schools in Illinois admitted 2,931 students, which was an increase of 122 students or 4.3%. The national admittance was 44,930 in 1954, an increase of 1,603 or 3.7% over 1953, when 43,327 new students were admitted.

Another encouraging factor is the increased employment of other workers for functions which do not require the nurses' special skills. The trend toward hospital staff nursing and away from private duty nursing means that more nurses are available for hospital employment.

Attention of the public to the careers available in the paramedical fields has been emphasized by the distribution of the new "Health Careers Guidebook" by the National Health Council to all high school councilors.

At present there are 79 schools of nursing in Illinois, 18 schools, 5 from downstate and 13 from Chicago, have full national accreditation, 45 schools have temporary national accreditation, and 16 are not accredited. Of the schools not nationally accredited three are in Chicago and thirteen are downstate.

Illinois has three programs that lead to a baccalaureate degree in nursing. Loyola University, St. Francis Xavier College for Women, and recently the University of Illinois have four year college programs for a B. S. Degree in Nursing.

UNIVERSITY AND COLLEGE PROGRAMS FOR GRADUATE PROFESSIONAL NURSES

Three Universities in Chicago offer the following programs:

1. DePaul University.
   The following programs are granted a Master of Science in Nursing Education.
   1. Administration of hospital nursing service.
   2. Administration of school of nursing.
   3. Teaching in a head nurse unit.
   4. Administration of hospital nursing unit.

   B. S. in Nursing.
   1. General Nursing (Supplementary, prespecialization).
2. Loyola University.
   B. S. in Public Health Nursing.
   Public Health Nursing (general staff).
   B. S. in Nursing.
   General Nursing.
3. University of Chicago.
   Master of Arts is the degree granted by:
   1. Administration of hospital nursing service.
   2. Administration of public health nursing.
   3. Administration of school of nursing and hospital nursing services.
   4. Administration of school of nursing.
   5. Teaching of physical and biological sciences.
   6. Teaching of Nursing (introductory course).
   7. Teaching clinical nursing.
   8. Teaching clinical nursing and nursing services supervision.
   9. Supervision of nursing service.
   10. Supervision of Public Health Nursing.
   11. Public health nursing (general staff).

Your committee has listed the graduate programs available in Illinois because the Department of Registration and Education of the State of Illinois has the following rules and regulations for accredited hospital schools of nursing:

"Director of School of Nursing shall:

2. Have a master's degree with a major in nursing education or nursing school administration, or have a Bachelor's Degree in nursing supplemented by advanced training or preparation in nursing education or nursing school administration."

"Nursing Arts Instructor shall:

2. Have a Bachelor's Degree or adequate academic and professional preparation in her teaching field."

"Clinical Instructor shall:

2. Have a minimum of two years college education in ward administration or teaching, educational psychology and methods of teaching, or a wide experience in the clinical area in which she is an instructor."

Schools that have an Educational Director will find it preferable for such an individual to have a master's degree with a major in nursing education or nursing school administration.

If an Assistant Director of School of Nursing is included on the staff she should have a Bachelor's Degree in nursing education or nursing school administration, etc.

SUMMARY

Your committee notes that there is one less school of nursing in the state of Illinois than there was in 1953. (It was reported to the House of Delegates at the 1941 annual meeting that there were 103 schools of nursing in Illinois.) We are aware that the admissions to the schools of nursing has increased 4.3%, but we wish to call your attention to the gradual up-grading of requirements for faculty members that has resulted in a shortage of qualified personnel, and has increased the cost of operating schools.

At the same time the population of the United States is increasing at a rate which continues to outrun expectations. Today our population is 165 million people, and ten years from now in 1965, if our present birth rate continues, the population may reach 190 million.

Respectfully submitted,

MAURICE M. HOELTGEN, M. D.
Chairman.
HOMER JUNKIN, M. D.
F. M. NICHOLSON, M. D.
JOHN LESTER REICHERT, M. D.
PAUL P. YOUNGBERG, M. D.
Committee on Nursing.

PHYSICAL MEDICINE AND REHABILITATION

TO THE MEMBERS OF THE HOUSE OF DELEGATES:

The Committee on Physical Medicine and Rehabilitation met on Saturday, March 5, 1955. All the members were present.

The meeting was opened for discussion of any matter which the members wished to present.

The problem of securing adequate prescriptions for physical therapy was brought up. It was felt that more could be done to educate physicians in this line. It was pointed out that there are some unqualified physical therapists who are registered in the state of Illinois. Discussion brought out that under the present law only qualified physical therapists can become registered.

It was agreed that the most important function of this committee is to keep the members of the Illinois State Medical Society informed regarding progress in the field of physical medicine and rehabilitation. Another function would be to meet any problems as they arise in this field within the state, and if necessary present them to the Society for consideration. Information about facilities for physical medicine and rehabilitation (and agencies related to this field) should be made known to the physicians in the state. A survey will soon be available which should then be published.

It was recommended that the Journal of the Illinois State Medical Society be used as a means of presenting such information.

Respectfully submitted,

EMIL D. W. HAUSER, M. D.
Chairman.
H. WORLEY KENDALL, M. D.
DISRAELI W. KOBAK, M. D.
STERLING PARKER, M. D.
RICHARD J. BENNETT, JR., M. D.
Committee on Physical Medicine and Rehabilitation.

POSTGRADUATE EDUCATION

TO THE MEMBERS OF THE HOUSE OF DELEGATES:

The Committee on Postgraduate Education has arranged a total of fifteen postgraduate presentations during the 1954-55 fiscal year. Harold M. Camp, M. D., secretary of the society, who attended all but one of the major meetings, estimates that more than 1,500 of our members have attended the postgraduate meetings. Eight-six teachers, all from Chicago, have contributed their time and energy to make these programs a success.

The Committee has held two meetings to consider the program for the next year and to review the program as carried out during the current fiscal year. These meetings were held August 5, 1954, and April 21, 1955.

The accompanying chart presents the record, which is broken down into three groups:

a) Eleven major meetings, each presented by teachers from the faculties of the five medical schools, or the staffs of major teaching hospitals in Chicago.

b) Three smaller meetings, one presented by three men, and two by four men, chosen without regard to teaching affiliations.

c) One Circuit Rider meeting. This part of the postgraduate education program was arranged by Edwin F. Neckerman, M. D., of Elmhurst, and the committee desires to express its appreciation to him. Dr. Harlan English had this to say about the circuit rider program:

"The man (William B. Dwyer, M. D., of Elmhurst, Clinical Instructor at the University of Illinois) you sent as a circuit rider to Tuscola, Paris and Lawrenceville, was thoroughly enjoyed by the doctors in these towns. If he wants to come back a year from now, I'm certain they'll be glad to see him again. He reported that he had a most enjoyable time doing it. In the case of these small societies that need a little outside stimulation, I still believe this circuit rider proposition is the best thing we can do for them."

In connection with the circuit rider program, the committee recommends that the communities that want this type of program should appoint someone locally in each town to be responsible for finding out what material is available. Requests for a circuit rider should be made as soon as this information is available, as it is extremely difficult to secure top level speakers on short notice.

The postgraduate conferences followed the established pattern by including a social hour and dinner. Some also included luncheon. At each meeting the Councilor for the district spoke briefly at the evening meeting on medical organization. The Councilor's name for each district where the meeting is to be held should always appear on the program, as directed by the Council. No deviation can be made from this by the program chairman of any county medical society. This policy can be changed only by Council action.

As to the scientific programs themselves, most of the programs were of the varied subject type, an individual speaker on a subject selected either by the program chairman of the county medical society, or by the institution giving the program.

There is a great deal of office detail connected with the preparation of these meetings. Briefly, the work involved is:

1. A detailed letter to the County Secretary outlining the necessary arrangements to be made by him.

2. A letter to the secretaries of surrounding counties (8 to 12 usually) telling them of the meeting, and asking their cooperation in publicizing the meeting.

3. A letter to the person who is responsible for arranging the scientific section of the program.

4. Preparing the program to be sent to Dr. Camp's office for printing, with copies to the County Secretary, Councilor for that district, the member of the committee in whose district the meeting is to be held, and the chairman of the Postgraduate Education Committee.

5. Letters to the speakers confirming the engagement, giving travel information, asking for any special equipment needed, and any other way in which this office might be helpful.

6. A thank-you letter to the person who arranges the scientific program.

7. Preparing a release to go to all newspapers and radio stations in and surrounding counties where the meeting is held.

8. Preparing a release for the Chicago Medical Society Bulletin and the Illinois Medical Journal.

We want to take this opportunity to express our great appreciation for the help of Dr. Camp and his office at Monmouth, and Mrs. Clara Mai Rutherford, for the efficient way in which this large mass of detail has been handled.

In addition to the work done at Chicago, Dr. Camp takes care of sending a letter to each member in the eight to a dozen surrounding counties, inviting him to attend the meeting. Ten days before the meeting, the same group is sent a printed official program, plus a return post card, addressed to the secretary of the host society to determine the approximate number who expect to be present and to remain for dinner.

Dr. Camp's office, at the request of the Council, is usually charged with the duty of making a guarantee to the hotel or club serving the dinner. We strongly urge that no guarantee be made until the middle of the afternoon during the conference, at which time a more accurate figure of those remaining for dinner can be determined.

Perhaps a brief explanation of how these programs are initiated will help in the organization of next year's programs:

The dates and places of conferences are set by the Councilors, and then submitted to Dr. Camp for approval. Once they are fixed, the chairman of the committee contacts someone at a school or hospital, and asks him to select good speakers.

Subjects suggested by the local medical society are given preference, but if no suggestions are forthcoming, they are selected by the chairman. The Committee is most anxious to have the local societies make their own selections for discussion.

The Committee recommends:

1. That the selection of places, insofar as possible, to hold the meetings be such that it will be possible for the speakers to arrive at the place of the conference and return to Chicago in one day. With the heavy schedule most of them are carrying, it is not possible for them to take more than one day away from their office, or teaching position.

2. That there be a definite clearance between the Councilor, the county medical society secretary and Dr. Camp as to the date and place of meeting. Before a date is submitted for clearance, the county secretary should check very carefully to see that there is no conflict with other meetings to be held in that area on the date of the conference. This would assure a larger attendance.

3. That the programs be arranged as far in advance as possible in order to secure top-level men. The Committee recommends that the times and places for these conferences be submitted early in the fall.

4. The Committee recommends that insofar as possible, that meetings be arranged for early autumn and early spring. April 30 is the end of the fiscal year, and no postgraduate conference should be scheduled after that date.

5. It is recommended that in the future the chairman of the Postgraduate Education Committee be notified as soon as possible, and before any arrangements have been made by an institution arranging the program, as to whether or not the local society has selected a dinner speaker. In general, the dinner speaker is either selected by the county medical society, or by the institution giving the program. This pattern has been followed with the exception of one conference which was held at Moline, where an embarrassing situation arose, because the program chairman selected a speaker from out of state. This was done after the program had been arranged by the school, and a speaker had been selected by them. As far as possible, an attempt has been made to provide a speaker on a non-medical subject, which would be of interest to both the doctors and their wives.

6. The Committee recommends that the program of postgraduate conferences be continued, both for teaching value, and for their organization value.

One dramatic incident resulting from the Postgraduate Conference held at Cairo was the saving of a patient's life. The county medical society had requested a paper on Afibrinogenemia. Dr. Robert J. Hawkins, Clinical Professor of Obstetrics and Gynecology, from the faculty of The Stritch School of Medicine of Loyola University, delivered a paper entitled "Uterine Hemorrhage with Reference to Afibrinogenemia." About a week after the conference, one of the doctors in that area had a patient suffering from afibrinogenemia. Remembering the paper and the treatment, he got in touch with Dr. Vaughn, who in turn contacted Dr. Hawkins. There was a supply of fibrinogen on hand at the hospital. Dr. Hawkins called the Chicago Police Department to transport the fibrinogen to the airport. There

POSTGRADUATE SUMMARY — 1954-55

Date	*Place*	*County*	*District*	*No. Speakers*	*Counties Covered*	*Releases Mailed*	*Faculty*
1954-55							
10-13	Freeport	Stephenson	1	7	8	122	Univ. of Illinois
10-21	Decatur	Macon	7	5	15	137	Michael Reese
11-17	Cairo	Alexander	10	7	13	91	Stritch-Loyola
3-3	Kankakee	Kankakee	11	9	8	135	V. A. Hospital
3-10	Jacksonville	Morgan	6	6	9	110	Northwestern Univ.
3-17	Centralia	Marion	7	5	10	82	Univ. of Chicago
3-30	Moline	Rock Island	4	5	12	140	St. Luke's Hospital
4-7	East St. Louis	St. Clair	10	7	13	122	Mt. Sinai Hospital
4-14	Mattoon	Coles-Cumberland	8	7	19	166	Henrotin Hospital
4-20	Galesburg	Knox	4	11	11	144	Stritch-Loyola
4-28	Springfield	Sangamon	5	6	13	154	Univ. of Illinois
11-18	Lincoln	Logan	5	3	8	100	Augustana Hospital
1-13	Olney	Richland	8	4	8	73	Univ. of Illinois
4-14	Bloomington	McLean	5	4	10	142	Univ. of Illinois
Circuit Rider Conference							
11-3 & 11-4	Tuscola, Paris, Edgar, Douglas & Lawrenceville	Lawrence	8				

Wm. B. Dwyer, M. D.
Elmhurst, Clinical Inst
Univ. of Illinois

were no patrol cars available at that moment, so two policemen, who were off duty, went to the hospital, picked up fibrinogen, took it to the airport, where it was put on a plane for St. Louis. The plane was met in St. Louis, and from there it was sent to Cairo by private plane. It was received in time to save the person's life.

The Postgraduate Education Committee always welcomes criticisms and suggestions which will improve the services of the Committee.

Respectfully submitted,

LOUIS R. LIMARZI, M. D.
Chairman.
GEORGE E. KIRBY, M. D.
Co-Chairman.
J. H. MALONEY, M. D.
N. C. BARWASSER, M. D.
JACOB E. REISCH, M. D.
JOSEPH J. GRANDONE, M. D.
F. W. SIEGERT, M. D.
WILLIAM H. SCHOWENGERDT, M. D.
MAX SAMTER, M. D.
N. A. THOMPSON, M. D.
PAUL S. BAUR, M. D.
EDWIN S. NECKERMAN, M. D.
WAYNE FLORA, M. D.
R. C. OLDFIELD, M. D.
JOHN LESTER REICHERT, M. D.
FREDERICK SELFRIDGE, M. D.
Postgraduate Education Committee.

RURAL MEDICAL SERVICE

TO THE MEMBERS OF THE HOUSE OF DELEGATES:

During the past year, the Committee on Rural Medical Service has done a variety of things which may be productive of improved health on the part of the citizens of our state.

We have cooperated with the Extension Service of the University of Illinois in a broad program of Health Education through the Home Bureaus and the Extension Service of the University. In cooperation with other interested groups in the State of Illinois, we are developing television and local group programs on cancer, tuberculosis, and poliomyelitis.

In an effort to hit at the source of part of our butter-fat subsidy program, Senator John W. Lewis of Marshall, Illinois proposed a plan for drinking up the surplus butter-fat instead of letting it spoil in storage. Senator Lewis' suggestion was to raise the minimum butter fat content of whole milk from 3.3% to a minimum of 4%. It is obvious that this would channel more wholesome milk to the customers and their children and thus a goodly amount of butter-fat would be used instead of churned. This idea has been plugged up by the farm organization in our state for several years and may or may not have some chance of passage.

During the year, the Committee on Rural Medical Service, through its participation in the Farmer-Doctor Loan Fund Board arrangement, contracted with twenty more students to enter medical school and at the end of their internship and military service return to a rural area of need in the State of Illinois. This program has attracted increasing attention nationally and may or may not represent an answer to the problem of physician distribution within our state.

At the request of the Illinois Agricultural Association's television group who put on "Farmtown, U.S.A." over WBBM, we suggested the use of Dr. Andy Hall, Dr. Donald Hartrich, and a couple of our students for one of their television shows. This was put on Sunday, March 13 and was thoroughly enjoyed by many citizens.

Dr. Coleman and the chairman appeared during the annual Health Improvement Association meeting at Decatur. We took part in a panel discussion on "What Doctors Think of the H. I. A." We both made an effort to give these good citizens the physician's sensible point of view about people taking care of themselves.

With the Illinois Agricultural Association's active support, we can anticipate that the Health Improvement Association movement in Illinois will increase numerically very rapidly during the next few years. What Health Improvement Associations have been able to bring in the form of better hospital and medical care to many of our rural families is nothing short of astounding. Dollar-wise, within a very short period *over* five million dollars worth of hospital and medical service has been paid for through the Health Improvement Association movement. Individual rural farm families could never have had this much benefit had not the Health Improvement Association movement been so actively supported by so many persons.

The chairman represented the committee and the State Society at the Tenth Annual Rural Health Conference of the American Medical Association held in Milwaukee, Wisconsin. Mr. Wallace Harris represented the Illinois Health Improvement Associations there and Miss Pauline Brimhall of the Extension Service at the University took part in the program. Dr. Charles Sutton represented the State Health Department. A Blue Cross representative, Mr. Robert Towne, certainly had some very glowing remarks to make about our Health Improvement Associations in Illinois. This most interesting conference was productive of many ideas. It is generally considered that the greatest need of our time, with an encreasing population and increasing complexity of life, is to develop and preserve our individuality. Any one person's benefit from society is a personal benefit. As we reap the rewards of our system, we must accept the responsibility of preserving freedom as an individual. The human soul is not and cannot be a mass produced product.

It was most obvious that all movements and developments have stemmed from the ideas of individuals. No one person, no one class or social group has any monopoly on new ideas.

Another profound observation that came out of this meeting was that some individuals become interested in one activity or one cause. Unless they enlarge their interests and become acquainted with other activities, there is great danger of their becoming one-sided for their pet causes and for that reason destroying their effectiveness.

One of the retarding factors in citizenship growth and responsibility is the fatalistic concept that events are beyond our control and that there is nothing we can do about them. Some persons even take the view that they are not responsible for their own conduct because of such a concept. Our resignation to the status quo certainly deadens our vision and destroys our own and our country's capacity for growth. A great advantage of the Health Improvement Association is that it exposes one person and another to the interests and viewpoints of the other fellow in health education matters. Everyone is more and more educated on the resources of the community, healthwise and otherwise, as well as the community's problems and needs.

Individual and local initiative in health improvement affairs are necessary to our state and national organizations as the feeding ground for new personnel and new ideas. Incidentally, these local groups keep the state and national organizations from becoming too "top-heavy." It is often observed that when groups of people think alike, there usually is little thinking being done. Rehashing old prejudices is no sign of thinking. Perhaps the greatest threat to our representative government is not attack from without but decay from within.

There is increasing evidence to your Committee on Rural Medical Service that the supply of physicians in Illinois is probably adequate and the distribution not 100% perfect. No one expects the distribution to suit the needs or ideas of all people. As one of the few states accepting foreign-trained physicians for licensure, we can anticipate an increasing number of such physicians within our state.

The greatest areas of need for hospital beds have been already supplied and few additional beds were put into rural areas during the last year. The need in the foreseeable future is the chronic disease infirmary type of institutional bed, preferably connected with an active general hospital but wherever located, reasonably supervised by trained ancillary medical personnel.

All in all, the past year has been one of slow but substantial progress in the matter of rural health service to the citizens of our state.

Respectfully submitted,

HARLAN ENGLISH, M. D.
Chairman.
G. C. OTRICH, M. D.
J. C. REDINGTON, M. D.
EVERETT COLEMAN, M. D.
Committee on Rural Medical Service.

THE PRESIDENT: I wish to introduce Dr. J. L. Gibbs of Havana, one of the boys who received his aid in medical education through the efforts of the Committee on Rural Medical Service. He graduated under this program. He is sent here as a delegate from his own county, Mason.

DR. GIBBS: Thank you very much Dr. Vaughn. I appreciate the opportunity to be here and hope I can make some reeturn.

THE PRESIDENT: I certainly appreciate having you here.

SCIENTIFIC SERVICE

TO THE MEMBERS OF THE HOUSE OF DELEGATES:

The Scientific Service Committee held one meeting the past year. This was a dinner session at the Hotel Sherman, September 30, 1954.

The Committee reviewed the proposed revision of the List of Speakers which, unfortunately, has not developed beyond the published request for new names and subjects and a circularizing of existing names in the Speakers' file.

The Chicago office was handicapped because it was operating with insufficient help. However, this situation has now been corrected, and it is hoped that the work on the revision can be resumed this summer.

The committee proposes to carry several appeals in the Illinois Medical Journal and the Bulletin of the Chicago Medical Society, as well as the various county medical society bulletins. The fact that the revised List of Speakers has not been forthcoming is to be regretted. The Committee realizes that the program chairmen and secretaries of the county medical societies depend on a timely revision to aid them in selecting speakers and subjects.

Seventy-seven speakers were scheduled for county medical society meetings and two other medical groups. The following chart illustrates the individual services.

As indicated in the chart, service has been given to two medical organizations not county medical societies. This service has been approved by Council authorization, provided all expenses for the speakers are assumed by the organization.

County medical societies are expected to pay expenses of the speakers whenever possible. The Scientific Service Committee's budget carries this need for those societies whose treasuries are inadequate. It is interesting that some large county medical societies do not even offer the speaker reimbursement for his expenses, and still further interesting that some speakers do not submit a bill to either the society or the Scientific Service Committee.

		Double Postcards	*Single Postcards*	*Press Releases*	*Society Speakers*
Bureau	1	535			20
DeKalb	5	379			42
Douglas Park Br.	4				
Greene		289			80
Henry	7	568			85
Illinois Acad. of Genl. Practice	1				
Iroquois	8	168			69
Kane	3				
Knox	5	389	449		85
Kankakee	2				
LaSalle	11	1,402			204
McDonough		421			61
Marion	3				60
Macoupin-Montgomery	6	389			112
St. Clair	2		154		9
Stockyards Br.	8				
Whiteside-Lee	11	1,007			163
	77	5,547	603		990

19 speakers scheduled beyond period covered by this report.

The number of county societies using the Scientific Service Committee's office varies. For example, DeKalb County Medical Society this year decided to schedule their own speakers until such time as we publish a revision of the List of Speakers. However, postcard notices and newspaper publicity are still handled by the Scientific Service Committee. Some societies consistently obtain their own speakers and release their own publicity, while others call on the Scientific Service Committee infrequently.

This past year two county medical societies gave the Chicago office one week's notice not only to obtain a speaker, but to release publicity. The requests were filled. The short notice request, however, not only creates a hardship on the staff doing the work, but it is not fair to the speaker. In both of these instances several telephone calls were made before a definite commitment was obtained.

The handling of postcard notices is a time-consuming effort, since each card is slip-sheeted by hand to avoid offset. This is a distinct service and should prove rewarding in a matter of attendance. Yet the Committee wonders how much value there is in sending duplicate notices to the following three county societies: Henry, Bureau and LaSalle. These three societies meet on consecutive days and their respective notices go to each other. This point has been brought up before. We know that no more than five, if that many physicians in one county go over to another society meeting. And rarely would one attend all three meetings in the same week, even though conveniently located. We have continued to service these counties because the program chairman or secretary has requested the service, but the Committee does question the value, particularly when it involves a group of societies meeting during the same week in the same area.

Your Chairman had the privilege of presenting a paper at the Annual Secretaries' Conference in Springfield, March 27, 1955, entitled "Long-Range Program Planning for County Medical Societies." On March 30, a request for a copy of this paper was received from the publication, "Medical Economics."

In brief, your Chairman said that the Scientific Serv-

ice Committee would like to re-emphasize that every effort should be made by the county medical societies to present the speaker early in the evening. On occasion, when the speaker cannot return to his home the night of the meeting, he does not object to sitting through a business session. However, the physicians who participate in the Speakers' Bureau of the Scientific Service Committee are busy practicing physicians and prefer to return home the same evening whenever possible. This, particularly if the speaker drives, makes the departing hour quite late when he is necessarily, because of a lengthy business session, presented at a late hour.

Your Committee recommends that county medical societies consider giving the program chairman an assistant. The program chairman is also a busy practicing physician and very often neglects to handle the details of the forthcoming meetings until a late date which places a hardship on the Chicago Office in getting the requested speaker and the desired topic. If the program chairman had an assistant, the assistant then could take over the office of the program chairman the following year. He would then be fully aware of the problems of choosing good program material to attract a good audience. A new assistant, who would subsequently take over the office, would benefit from two years' experience instead of going into the office of program chairman without previous familiarity with the work.

The Scientific Service Committee believes there are too many medical meetings. We admit this but must remind you that your county medical society meeting is an important one. It is your one medium of holding your members together and of making them vitally interested in their own local society. It is much easier to plan a long-range program well in advance so that the mechanics can be moving along efficiently to provide this service. In this manner, your membership can be informed on what is coming. To obtain their own opinion would not only prove to be a valuable public relations gesture, but would certainly assist the program chairman in selecting the material. The individual members would realize that they themselves are taking an integral part in their own county medical society activities.

Since the Committee has had many reports that the attendance at county medical society meetings has been very small in contrast to the proportion of members, your Chairman, in his presentation, made the following suggestions: "Plan your programs well in advance. Choose an alert program chairman and give him an assistant. Let them poll the individual membership to obtain the predominant interests in subject material. Set your programs up well in advance on the Speakers' Blanks provided by the Scientific Service Committee whose office will expedite the handling of details in every way. Then publicize your meeting locally. While the newspaper publicity is released from the Chicago Office, talk up your meetings at the hospital. Stimulate interest in your meetings and thereby stimulate interest in a good attendance. Attention to these details will prove that long-range program planning can be effective in maintaining active members who are interested in working together for a better society."

Your Chairman has presented an up-to-date report at each session of the Council during the past year. Copies of these reports have been sent to each member of the Committee to keep him informed. Your Chairman visits the Chicago Office once each week. He is in almost daily telephone communication with the Secretary of the Educational Committee who directs the work of the Scientific Service Committee.

Your Committee wishes to express its appreciation to Miss Ann Fox, Secretary of the Educational Committee, who so ably and efficiently directs the work of the Scientific Service Committee. Appreciative acknowledgement also goes to Mrs. Kay Simmons who handles all the detail incident to the preparation of postcard notices and newspaper publicity.

The Scientific Service Committee submits this report as a brief review of its functions. In no way does it reflect the detail involved or the hours consumed to attain its objective: Service to the County Medical Societies. To the House of Delegates and the Council of the Illinois State Medical Society, the Committee says "thank you" for your confidence.

Respectfully submitted,

Louis R. Limarzi, M. D.
Chairman.
J. K. Hanson, M. D.
William H. Whiting, M. D.
Gilbert Marquardt, M. D.
Jerome T. Paul, M. D.
Harry A. Oberhelman, M. D.
Charles D. Krause, M. D.
Max Hirschfelder, M. D.
Committee on Scientific Service.

TUBERCULOSIS CONTROL

To the Members of The House of Delegates:

The meeting of the Tuberculosis Control Committee of the Illinois State Medical Society was held March 6, 1955, and the tuberculosis problem in the State of Illinois was discussed.

Dr. Meyer Lichtenstein, Medical Director of the Municipal Tuberculosis Sanitarium, Chicago, Illinois, reported the following: There was a 13% reduction in mortality; an increased number of admissions to the sanitarium; 606,163 survey films developed and read and 1,158 patients received out-patient chemotherapy for an average of 2,500 patients on chemotherapy at all times as compared with 1,000 during 1952. The long hospital waiting list was completely exhausted in August, 1954, and since that time patients have been admitted within a few weeks of the time of application. New active cases reported in Chicago were tentatively set at 4,200, as compared with 3,737 in 1953.

The Cook County Suburban Tuberculosis Sanitarium District reported 317 new cases and have a preliminary figure of 61 deaths which was one (1) more than occurred in 1953. A total of 216,040 70 mm. films was taken in 1954 in the cooperative program between the District and the Tuberculosis Institute of Chicago and Cook County, and the various health officers and the County Health Department. An additional 32,000 hospital admission films were taken in Suburban Cook County by the various hospitals. This gives us a figure of almost one-fourth of a million screening films done by the work of the District and the Tuberculosis Institute of Chicago and Cook County.

The Illinois State Tuberculosis Hospital at Mount Vernon operated at practical capacity throughout the fiscal year ending June 30, 1954. A total of 250 patients were admitted from thirty-five (35) counties. The Mt. Vernon Sanitarium also serves as a surgical center for other sanitariums in southern Illinois. The Chicago State Tuberculosis Hospital was dedicated on October 11, 1953, and received its first patient on November 9th of the same year. At the end of the fiscal year there were 168 admissions. By December 31, 1954, there were an additional 212 admissions closing the calendar year with 218 patients.

The number of deaths from tuberculosis in Illinois residents during 1954 decreased approximately 16% when compared with the 1953 figures. The total number of deaths in 1954 among Illinois residents is set provisionally at 1,052. Among this number, 708 were residents of Chicago and Cook County, and 344 of downstate areas. The provisional death rate for Illinois from tuberculosis declined from 13.9 in 1953 to 11.6 in 1954.

It is estimated that approximately 1,500,000 x-rays were taken by mobile units operated by the Department of Public Health, the Chicago Municipal Tuberculosis Sanitarium, the Tuberculosis Institute of Chicago and Cook County, the Cook County Suburban Tuberculosis Sanitarium Board and the Sanitarium Boards of Lake, Kane, DuPage and Winnebago Counties, in addition to general hospital admission photofluorographic x-ray units throughout the state, including those in mental and penal institutions. This number represents approximately one-sixth of the entire population.

The Tuberculosis Control Services of the Illinois Department of Public Welfare presents a well documented over-all program for treatment of tuberculosis in these institutions. All employees of the State Institutions are checked prior to employment and every six months thereafter. Employees assigned to the Tuberculosis Units are x-rayed every three months.

The Department's Division of Tuberculosis Control supervises the control program in 23 institutions, 13 State Hospitals and 11 educational-correctional institutions with a total population of about 51,000 residents and 11,000 employees. The State Hospitals have a patient population of 47,117.

Approximately 150,000 films were taken during the last fiscal year. A total of 272 out of 13,747 patients newly admitted to the Illinois State Hospitals or about 2% were found to have active tuberculosis on admission. During the same period 90 out of 47,117 State Hospital patients, or 0.19% ,of the patient population developed pulmonary tuberculosis during their hospital stay. This is a decline in incidence of newly detected active pulmonary tuberculosis from 1945 to 1954 of 1.9% to 0.19%, or a reduction of 90 per cent during this period of time.

An active surgical and bronchoscope service has been set up at the Kankakee State Hospital. A large number of thoracoplasties, lobectomies and segmental resections was performed without serious complications.

Nineteen hundred (1900) patients were isolated on the Tuberculosis Units of the State Hospitals. Three hundred and sixteen (316) patients were discharged from the Tuberculosis Hospitals during the last year; 211 left the hospital and 105 were discharged as inactive to the regular hospital wards. There were 2,550 inactive cases of tuberculosis in the Illinois State Mental Institutions; 209 of them have shown evidence of reactivation during the last year.

There were 46 deaths due to tuberculosis in State Hospitals during 1954. This is a decline from 1945 of 0.8% to 0.10% of the resident population. This is still a high rate being approximately 100 per 100,000 patient population. The tremendous decline from 1945 speaks for itself. This has been one of the big factors in the decrease in mortality in downstate Illinois.

A similar report comes from the Department of Public Safety. The Tuberculosis Control Program began in the prisons October 3, 1939, with the opening of a Tuberculosis Hospital Unit in the Pontiac Branch of the Illinois State Penitentiary. Since then this program has been introduced into other branches of the Department and at present includes every institution—Pontiac, Joliet-Stateville, Menard, the Vandalia State Farm and the Dwight Women's Reformatory.

A screening and isolation program is in effect throughout these institutions. Routine x-rays are taken on 4x5 films. Suspicious findings are checked by 14x17 films. Tuberculosis control physicians interpret all x-rays with the pertinent physical findings.

The report indicates that adequate facilities are present in all institutions except at the Vandalia State Farm. At the present time 56 cases of tuberculosis are being treated at the Pontiac Branch, three (3) at the Dwight Women's Reformatory, and eleven (11) at the Vandalia State Farm. Facilities for the isolation and treatment of active cases of tuberculosis is not satisfactory at Vandalia, since the patients are housed in a dormitory with 60-80 cases of non-tuberculous chronic diseases.

The Control Officer recommends that a 25 to 40 bed modern tuberculosis hospital be erected at Vandalia. The erection of this hospital to correct this deficiency is necessary because misdemeanants cannot be transferred to the Tuberculosis Unit at Pontiac because the latter institution is for felons only.

The Tuberculosis Control Committee of the Chicago Medical Society has studied the mortality and morbidity figures in Chicago and Cook County and found that the mortality rates are showing marked improvement. However, the morbidity rate remains at a high level. The Committee has been directing its attention and studying the possibility of enlarging the routine hospital admission x-rays in Chicago. They have come to believe that this is the most urgent matter—controlling tuberculosis in the Chicago area.

The Committee is also directing its attention towards educating the general practitioner so that each doctor's office in the city shall become a diagnostic center for tuberculosis.

The Seal Sale Organizations both report on local research funds. The Research Fund of the Illinois Tuberculosis Association has just recently been implemented and projects are now being allocated. The Chicago Tuberculosis Institute spent $10,000 on research projects in Chicago. It is to be hoped that these programs can be enlarged.

Studies made by the Tuberculosis Institute of Chicago and Cook County on percentage of cases found by mobile x-ray screening for the year of 1953, showed that 21% of the new cases detected by this method and spot checks indicate that the percentage has increased to 22% in 1954.

The Illinois Tuberculosis Association reports that 93 of the 101 counties in the state conducted some type of mobile x-ray survey. Tuberculin testing was done in 77 counties. Forty-seven (47) counties have chest clinic facilities or use facilities in nearby counties. Forty-nine (49) general hospitals in downstate Illinois have routine admission x-ray programs.

The Illinois Tuberculosis Association has favored the introduction of a bill in the state legislature which would provide for annual chest x-ray examinations of all public school teachers and other school employees, including food handlers, bus drivers and maintenance personnel.

The Chairman of the Council of the Illinois State Medical Society requested an opinion on the role of the general practitioner in the care of tuberculosis patients.

The committee has studied this matter and the members of the Committee feel that the general practitioner should play an increasingly important role in the control of tuberculosis. A considerable number of articles have been published indicating that patients with pulmonary tuberculosis can be managed at home with chemotherapy drugs if the conditions are suitable. However, it is the committee's considered opinon that these cases are still the exception rather than the rule, and that the majority of patients should have a period of hospitalization and study before being allowed to continue on an out-patient basis. It is true that while the private physician may satisfactorily carry out a treatment program it is best preceded by a program of hospital treatment and the therapy should be carefully weighed before the patient is discharged. It is believed by members of the committee that the private physician might very well carry on the home treatment phase of tuberculosis treatment providing he has the assistance and guidance of a chest specialist This advice and guidance is necessary because of the many pitfalls and the rapidly changing methods in treatment. The drugs may cause toxicity, deafness, loss of vestibular nerve function, serious peripheral neuritis and blood dys-

crasia. Successful treatment requires using the correct combination of drugs and other forms of therapy such as—excisional therapy which is frequently indicated. If chemotherapy is given for too short a period, or if the therapy is interrupted, or if the optimum time for surgical intervention is not selected, the percentage of successful cures will be greatly reduced and the number of relapses will be greatly increased.

It is the considered opinion of the committee that the general practitioner should:

1. Skin test all patients seen in his office or hospital.
2. Should recommend annual x-rays on all positive reactors.
3. All open cases of tuberculosis with active disease should be sent to a tuberculosis hospital.
4. Suspect cases should be studied in detail with the assistance of a chest consultant, or tuberculosis clinic. No treatment should be started on such suspect cases until all the diagnostic measures have been exhausted. This would include—skin testing, sputum and gastric cultures, and bronchoscopic smears and cultures. If a diagnosis of tuberculosis is proven such cases should receive the same therapy as outlined above. Some suspect cases may be treated without bacteriological proof but the treatment must be pursued to its completion and therapy should be given over a period of not less than six (6) months and usually twelve (12) to eighteen (18) months. Failure to carry out this provision will lead to treatment failure.
5. Patients discharged from the tuberculosis sanitariums under antimicrobial therapy should be treated by the private physician under the guidance of the chest consultant or chest clinic. The State Health Department and the State, Municipal, and County Tuberculosis Hospitals, or the corresponding Sanitarium Boards, should make such consultations and advice available to the general practitioner in all the 101 counties in the state where it is not now available. It would be desirable for Sanitarium Boards, local Health Departments or the State Health Department to make these drugs available to the practitioner so that he may secure for the patient the most economical treatment cost. This has been done in other diseases, such as syphilis. Therefore, there is ample precedent for this practice.

If these provisions for treatment are not carried out the profession will have the responsibility for an unnecessary number of treatment failures.

The committee recommends that the House of Delegates endorse the following recommendations of the committee as the policy of the Illinois State Medical Society with regards to tuberculosis.

1. That we again endorse the principle mass x-ray survey and encourage the continued use of this method throughout the 101 counties in the state and the metropolitan area of Chicago.
2. Endorse in principle a law to require an initial employment chest x-ray of all employees of public and private schools in the State of Illinois with provisions for an annual x-ray of all such employees.
3. The committee recommends that the Society endorse the principle of the five-man board for the Chicago Municipal Tuberculosis Sanitarium.
4. The committee recommends that the State Health Department be requested to set up a limited number of security beds in the two (2) State Tuberculosis Hospitals.
5. The committee recommends to the House of Delegates that they endorse the principle of routine x-rays for all hospital admissions in the State of Illinois. And recommends that all members of the Illinois State Medical Society use their influence to set up such provisions in their own individual hospitals. And where such provisions are not available the House of Delegates should recommend that the members of the society order routine chest x-rays on all their patients whose illness requires hospitalization.

Respectfully submitted,

GEORGE C. TURNER, M. D.
Chairman.
JAMES H. HUTTON, M. D.
WILLIAM J. BRYAN, M. D.
DARRELL H. TRUMPE, M. D.
BERNARD KLEIN, M. D.
CHARLES K. PETTER, M. D.
Committee on Tuberculosis Control.

DR. GEORGE C. TURNER: I have a brief supplementary report.

Since the last meeting of the Tuberculosis Control Committee the Legislature has become quite active and there are a number of bills in which we are rather vitally interested.

First, Senate Bill No. 495, which is a money bill for the State Health Department. On Page 4, line 3, the item for medical services of the State Tuberculosis Hospital in Chicago now reading $1,785,500 should read $1,980,500, in order that this hospital can be operated at its full capacity.

Second, in this same bill, Page 5, line 7, now reading $3,800,000, state subsidy for tuberculosis hospitals having deficiencies, should read $5,000,000. This Society has been instrumental in getting this money, $5,000,000. We are sure in the next biennium this $5,000,000 will be needed.

The next item we should act on now because it is in committee hearing and can be killed in committee hearing tomorrow morning in Springfield. I move you that we suspend the rules and consider this matter at this time. (Motion seconded by Dr. Mather Pfeiffenberger, Alton, and carried).

I move that the legal representatives of the Society, Mr. Oblinger and Mr. Neal, send notice to the Chairman of the Public Welfare Committee, meeting in Springfield tomorrow at 10 o'clock, on Senate Bill No. 559 which is a bill to inject the means test on all cases admitted to the tuberculosis hospitals. Illinois has been in the foreground of this and we see no reason for turning a cold back on this bill. (Motion seconded by Dr. Harry Mantz, Alton).

DR. E. S. HAMILTON, Kankakee: I would like to ask if that has been referred to the Committee on Public Relations and Legislation for their consideration.

DR. TURNER: No, it has not. The bill came into the Legislature without our knowing about it. It is before the Welfare Committee and could be killed rather easily by studied opposition. It came to our attention last Saturday.

DR. C. PAUL WHITE, Kewanee: I would like to propose an amendment to the motion that we refer this matter to the Committee on Public Relations, as Dr. Hamilton referred to, with the request to act for the House. I move that as an amendment. (Seconded by Dr. Charles H. Phifer, Chicago, and carried).

The motion as amended was carried.

THE PRESIDENT: This will be referred to Dr. Hopkins' Committee.

DR. TURNER: There are two more bills. House bill No. 582 is a bill to inject politics into sanitarium boards and make county supervisors members of these boards, in some instances appointing lay boards rather than a medical set-up. We believe this bill should not be passed.

Senate bill No. 338 sponsored by Broyles and Crisenberry is now in third reading. It is a bill to supply 50 additional beds at the Mount Vernon Sanitarium at a cost of $550,000 and presumably would take two years

to build. The Committee feels that with 230 vacant beds in downstate Illinois as of May 1st, this is an unwarranted expenditure.

VOLUNTARY PREPAYMENT PLANS FOR MEDICAL AND SURGICAL CARE

To the Members of The House of Delegates:

This year has again seen a marked growth and development in the field of voluntary prepayment insurance against the cost of illness. It cannot be too emphatically stated that the safest and broadest voluntary insurance coverage possible is also the best insurance against socialization of medicine. Some of the companies and plans throughout the country are now offering more comprehensive contracts to cover the cost of illness, and it is hoped that in the very near future this will also be true of the insurance in force in Illinois.

The Committee believes that the time honored American philosophy of the individual, or family unit, being responsible for the purchase of goods or services, which includes insurance, is still the ideal American philosophy. In other words, insurance should be considered as an aid to help the individual help himself.

It is equally true that while insurance is designed to help people pay their medical bills, it definitely is not an excuse or reason for the physician to increase his charges. The purposes for which insurance is designed are defeated when any physician adopts that attitude.

Progress has been made at the national level in the simplification of insurance claim forms, as only recently was a new simplified claim form approved by the House of Delegates at its Clinical Session. Additional ones are to follow, it is hoped, in rapid succession. This will obviate the need of a large amount of paper work on the part of the physician.

Members of the medical profession should not lose sight of the fact that it is necessary for the patient who is covered by insurance, in most instances, to obtain proof of eligibility for benefits from his physician.

The Illinois Plan:

One additional company, The G. H. Poulsen Company, has submitted contracts, which have been approved by the committee, for participation in the Illinois Plan.

All of the contracts as at present offered, differ in no great respect from each other, and there have been no marked changes in the type of policy now being written.

As of the end of 1953, a total of 526,195 residents of Illinois were insured under policies approved for participation in The Illinois Plan. Of these 315,355 were subscribers, and 210,840 were dependents. Although figures for the year 1954 are still incomplete, those now available indicate that total enrollments of Illinois Plan companies increased very substantially during the year.

Blue Shield Plans:

The Blue Shield Plans throughout the State of Illinois during the year 1954 showed considerable progress. These plans operate throughout the state, some of them limiting their efforts to essentially local areas, while the Rockford Blue Shield Plan and Illinois Medical Service, (which was originaly the Blue Shield Plan of the Chicago Medical Society) operate in many counties. Illinois Medical Service was last reported to be operating in 97 of the 102 counties of the state.

The Blue Shield Plan at Rockford had 65,209 members as of December 31, 1954, including 24,729 subscribers and 40,480 dependents. It had 7.67% of the 850,078 population of its area enrolled, up from 6.14% a year previous. Its assets totalled $247,139.18 and reserves $126,722.87. Its total income was $405,877.50, of which it paid out $300,455.65 in medical and surgical benefits Operating expense was $71,651.55 or 17.65%.

At Moline and Alton the Blue Shield groups showed similar progress. Moline had 27,464 members, 11,477 subscribers and 15,987 dependents. It was serving 20.56% of its 133,558 area population, up from 18.46% the previous year. Assets totalled $145,748.97 and reserves $85,278.95. Total income was $311,799.20, of which it paid out in benefits $233,852.34. Operating expense was $41,543.13 or 13.32%.

Alton had 20,585 members, 9,098 subscribers and 11,487 dependents. It was serving 3.88% of its 530,442 area population, compared with 3.49% in 1953. Assets totalled $107,600.14 and reserves $46,216.11. Total income was $253,276.51, of which it paid out $199,474.90 at an operating cost of $42,510.49 or 16.78%.

The Board of Trustees of the Illinois Medical Service (Blue Shield) with headquarters in Chicago, report the following figures as of December 31, 1954:

Total membership	1,084,573
Added in 1954	154,559
Percentage Increase	14%
Income from Members	$9,617,819.09
Benefits Paid (to M. D's.)	7,348,569.38
Members involved	135,523
Operating Costs (Dec.)	9.94%
Assets	$8,214,509
Increase in 1954	$1,675,262
Percentage of increase	20%
Reserves (unallocated)	$5,700,006
1954 Increase	$1,308,239
Per member	$5.42

Effective August 15, benefits were increased without any increase in membership dues. Benefits included increased allowances for a number of operations and coverage for many of the commoner types of surgery performed in a doctor's office. Substantially increased were allowances for in-hospital medical (nonsurgical) care. Many anesthesia allowances were increased, the maximum being raised from $25.00 to $35.00. Maximum radiology and pathology benefits were made available in a 90 day period instead of per calendar year.

The first non-group (individual) enrollment for this Blue Shield and affiliated Blue Cross Plan was made available in the Decatur area in 1954. Plans are to extend this non-group enrollment into other sections of the state sometime during 1955.

Illinois thus had 1,197,831 of its citizens on the medical/surgical expense rolls of Blue Shield plans alone. No current figures are available for private carriers, although it is estimated that the total would be much higher.

It is believed that well over 100,000,000 persons in the United States are covered by some form of hospitalization or medical/surgical care insurance. The growth of the voluntary prepayment movement in this country has been phenomenal and the growth in Illinois reflects this trend. Further growth, however, is needed, together with expansion into other fields such as the problem of major medical coverage. To remain in the forefront the voluntary plans must be alert to the desires of the public if the continuing threat of compulsory governmental health insurance is to be thwarted.

Respectfully submitted,

Percy E. Hopkins, M. D.
Chairman.
Warren W. Furey, M. D.
Vice-Chairman.
Edwin S. Hamilton, M. D.
Jacob E. Reisch, M. D.
David B. Freeman, M. D.
Thomas J. Kelly, M. D.
Ex-Officio:
Arkell M. Vaughn, M. D.
Joseph T. O'Neill, M. D.
Harold M. Camp, M. D.

Committee on Voluntary Prepayment Plans For Medical and Surgical Care.

THE PRESIDENT: The next item on the agenda is unfinished business.

THE SECRETARY: There is no unfinished business.

THE PRESIDENT: We now come to new business. We have with us Dr. George Lull, Secretary of the American Medical Association. I would like to have him say a few words to the delegates.

DR. LULL: This is the fourth state medical society meeting I have attended this month and I am really proud of this one, though I am proud of the others and I have no doubt that this one will meet the same criteria that the others do. They have had a larger registration than usual. We can be right proud of the Illinois State Medical Society. One thing they have done that is outstanding — the others are catching on slowly — and that is the way they have supported the American Medical Education Foundation. This has been supported by our society better than by any other society in the United States. It is true they are beginning to get donations from other states because they see this cause is a good one and that we are doing something that we have a right to be proud of. I am very glad to be able to participate in these meetings.

You travel around the United States and you find the problems in most of the state societies are similar. They may have a different problem in the South than in the North but the basic problems are the same. They are those things that you delegates and officers thresh out in the American Medical Association. I want to pay tribute to the delegates to the A.M.A. I have worked with them very closely, as secretary for several years and before that as a delegate. When I was a delegate it took two years to learn what it was all about. It is a strange thing to look back on the activities of the House of Delegates and to find how few mistakes have been made. Sometimes you find something on which you did not agree, but time usually finds that the delegates were right. You can be justly proud of the men who represent you on the national level.

THE PRESIDENT: Under new business we will have the introduction of resolutions and their referral to the proper committees.

THE PRESIDENT: We have one resolution in the Handbook, page 175, on the Educational Fund. Dr. Charles K. Wells, delegate from Jefferson-Hamilton County will read the "resolved", and the resolution will be referred to Reference Committee "E".

EDUCATIONAL FUND

WHEREAS: The Illinois State Medical Society has approximately 10,000 members and each member is required to send $65 to the State Society annually. Of this $65, $25 goes to the A.M.A., $20 for State dues, and $20 is sent to the American Medical Education Foundation to be distributed to schools as they see fit with no strings attached, and

WHEREAS: Of the 48 states in the Union, Illinois is one of some 6 or 7 that are collecting $20 each from their members for this fund, therefore be it

RESOLVED: That the House of Delegates oppose further payment of this extra $20 until such states as New York, Pennsylvania, Ohio, California, Missouri, and other states of the Union exact the same amounts from their various members to be paid into this Education Fund.

Resolution submitted by Jefferson-Hamilton County Medical Society, passed January 27, 1955.

CHARLES K. WELLS, M.D.
Delegate, Jefferson-Hamilton County Medical Society.

THE PRESIDENT: The second one is printed on page 176. Dr. Maurice D. Murfin, Mason County, will read the "resolved".

DR. MURFIN: There are some changes in the resolution from the printed copy, so I will read the entire resolution.

MEDICAL CARE INSURANCE POLICIES

MACON COUNTY SOCIETY

WHEREAS: Medical insurance has enjoyed acceptance by the public and the medical profession as among the desirable methods of helping defray the costs of health care: and

WHEREAS: The members of the American Medical Association, State and County Medical Societies are bound by the principles and code of ethics of the American Medical Association: and

WHEREAS: The Illinois State Medical Society and American Medical Association have affirmed that Anesthesiology, Pathology, and Radiology constitute the practice of medicine: and

WHEREAS: Certain insurance companies issue and certain corporations accept medical care policies which provide payment for electrocardiograms, x-ray examinations and x-ray therapy, and laboratory examinations for non-hospitalized out-patients payable only to hospitals; this payable in some cases only to the hospital if the hospital issues the bill or the work is done by a salaried employed physician: and

WHEREAS: Such provisions encourage and further the practice of medicine by hospitals and limit the patient's free choice of physicians resulting in unfair competition and discrimination against those physicians doing special examinations outside of hospitals: and

WHEREAS: These provisions tend to encourage the practice of employment of physicians by hospitals, and

WHEREAS: Corporations and insurance companies are operating under the capitalistic system of free enterprise as does the medical profession, therefore be it

RESOLVED: That corporations and insurance companies should not be a party to insurance contracts that tend to undermine the medical profession by encouraging any group whether hospitals, corporations, insurance companies or government to control the medical profession and thereby lower the standard of medical care to our people, and be it further

RESOLVED: That all medical insurance companies and corporations should, in formulating their medical insurance plans, adhere strictly to the basic principles of the medical profession as enunciated by the American Medical Association, and be it further

RESOLVED: That any medical service which is to be the basis of a benefit payment shall be stated as a medical service and shall not be referred to in such terms as "Hospital Service", "Auxiliary Service", etc. nor shall such medical service be qualified by such phrases as "when rendered by a salaried employee of a hospital" or "when rendered by an employee of a hospital", or any wording which would convey a similar meaning, and be it further

RESOLVED: That the Macon County Medical Society go on record as opposed to any insurance plan that will tend to encourage exploitation or discrimination against any member or group of members of the medical profession, and a copy of this resolution be sent to the Illinois State Medical Society, the Illinois State Chamber of Commerce and the corporations and insurance companies operating in this state.

This resolution was passed on January 7, 1955 by the Macon County Medical Society.

Maurice D. Murfin, M.D.
President

J. W. Little, Jr., M.D.
Secretary

THE PRESIDENT: This will be referred to the Reference Committee on Miscellaneous Business.

The next resolution will be presented by Dr. W. H. Schowengerdt, Champaign County.

DR. SCHOWENGERDT: You will find this resolution on Page 177 of the Handbook. The reason for this resolution is as follows:

A survey in December of last year showed a shortage of 5,000 or 6,000 registered nurses in the State of Illinois. Since December of last year we have had about four training schools in the southern part of the state closed. Now if we are short that many registered nurses and we are closing our training schools, something is wrong. It is not due to pressure by the State Department of Registration and Education saying you must close your training school. It is due to the constant upgrading of requirements which these people are pushing down the throats of those who are attempting to do a good job in their communities. You men in southern Illinois have no schools below a line running through Champaign and Danville. The school in East St. Louis closed last week because of inability to teach students resulting from the constant upgrading of requirements. They inspect your hospital, and say, "you must set off two rooms, one on each floor for classroom." They inspect the quarters of the nurses, and say, they must have private rooms, and suggest many other impossible changes. Is that the function of the Department of Registration and Education? It means that either you will have to get these people to come down and use some sense or we will have to request the Legislature to change the law so that we can educate medical and surgical technicians in order to take care of the sick the way they should be cared for. I could go on indefinitely but prefer to read the resolution. I wish the members of the House of Delegates would get this thought: Does the family go to the superintendent of nurses to complain? No, they come to you. We are primarily responsible and we will have to take the bull by the horns and straighten it out. There is one group of doctors and hospital administrators who have gone to see the Governor. We got some results but we need more help. I will read the "resolved".

STUDENT NURSES' TRAINING

WHEREAS: A continuing supply of trained nurses is an absolute requisite to the operation of community hospitals, and

WHEREAS: Many hospitals in the State of Illinois have had to stop the education of trained nurses for various reasons, and

WHEREAS: A most important cause of nursing school closure is the unrealistic, arbitrary, and constantly upgrading of rules and regulations promulgated by the Department of Registration and Education in the State of Illinois, and

WHEREAS: A continuing pattern of arbitrary regulations without regard to the elemental community needs in our great state can only result in fewer and fewer of our young women becoming nurses; therefore be it

RESOLVED: That the Illinois State Medical Society and its Members encourage Community Hospitals which operate training schools to increase their efforts at educating young women for nursing in any reasonable manner which is in the best interest of local community betterment and without lowering present academic requirements, and

FURTHER, That the Illinois State Medical Society request that the Governor of the State of Illinois appoint a separate Commission composed of practicing physicians, nurses, hospital administrators, and educators to regulate schools of nursing and to develop such a program.

Submitted by THE CHAMPAIGN COUNTY MEDICAL SOCIETY.

CARL GREENSTEIN, M.D.
President.
LEO L. ROSEMAN, M.D.
Secretary.

THE PRESIDENT: This resolution will be referred to Reference Committee "E", Dr. John Wolff, Chairman.

The next resolution will be presented by Dr. Lloyd J. Hill, Secretary of the St. Clair County Medical Society.

POST-MORTEM EXAMINATIONS

WHEREAS: The autopsy rate necessary for training hospitals is to be raised from 25% to 40% of deaths and the present law in Illinois makes it mandatory that the surviving spouse or all of the children sign permission for a post-mortem examination;

BE IT RESOLVED: That this Society expresses the wish that the requirements for post-mortem examination be liberalized so that it be possible to obtain a higher percentage of examinations.

Submitted by The St. Clair County Medical Society.

LLOYD J. HILL, M.D.
Secretary.

THE PRESIDENT: This resolution will be referred to the Reference Committee on Reports of Standing Committees, Dr. Whiting, Chairman.

The next resolution from the Saline County Medical Society appears on Page 178 of the Handbook and will be read by Dr. N. A. Thompson of Eldorado.

DRUG DISPENSING

WHEREAS: Physicians have been dispensing drugs since the days of Socrates; and

WHEREAS: Patients, at least of most general practitioners expect to receive part or all of their medication directly from their family physician; and

WHEREAS: The family physician has had adequate training to enable him adequately to dispense medication properly, and is fairly competent to do so; and

WHEREAS: It is not the practice or intent of physicians to compete with drug stores, to dispense medications or appliances for pecuniary profit, but on the contrary the dispensing is closely linked with the economy and convenience of the patient: therefore be it

RESOLVED: That the House of Delegates of the Illinois State Medical Society meeting in Chicago on May 17 to 20, 1955 adopt the following resolution; that section 8, Chapter 1, of the Code of Ethics of the American Medical Association be eliminated.

"It is unethical for a physician to participate in the ownership of a drug store in his medical practice area unless adequate drug facilities are not otherwise available. This inadequacy must be confirmed by his local component Medical Society. The same principle applies to physicians who dispense drugs or appliances. In both instances, the practice is unethical if secrecy or coercion is employed, or if financial interest is placed above the quality of medical care. On the other hand, it may be advisable or even necessary for physicians to provide certain appliances or remedies without profit, which patients cannot secure from other sources."

And the following substituted:

"It is unethical for a physician to suggest or request any person to have a prescription filled at a drug store in which the physician has a financial interest or from which he may either directly or indirectly expect a pecuniary return. It is not unethical for a physician to dispense drugs or appliances at profit, except where the physician's financial interest in such dispensing is placed above the quality of medical care."

BE IT FURTHER RESOLVED: That this House of Delegates of the Illinois State Medical Society instruct its delegates to the Annual American Medical Association meeting at Atlantic City on June 6 to 10, to introduce,

and support this resolution, to the American Medical Association House of Delegates.

Introduced by The Saline County Medical Society.

THE PRESIDENT: This will be referred to Reference Committee "A".

There are two resolutions from Ford County which were printed in the Handbook. Dr. Paul W. Sunderland, the President of the Ford County Medical Society, will read them.

STUDENT NURSES' TRAINING

WHEREAS: A continuing supply of trained nurses is an absolute requisite to the operation of community hospitals, and

WHEREAS: Many hospitals in the State of Illinois have had to stop the education of trained nurses for various reasons, and

WHEREAS: A most important cause of nursing school closure is the unrealistic, arbitrary, and constantly upgrading of rules and regulations promulgated by the Department of Registration and Education in the State of Illinois, and

WHEREAS: A continuing pattern of arbitrary regulations without regard to elemental community needs in our great state can only result in fewer and fewer of our young women becoming nurses; therefore be it

RESOLVED: That the Illinois State Medical Society and its members encourage community hospitals which operate training schools to increase their efforts at educating young women for nursing in any reasonable manner which is in the best interest of local community betterment and without lowering present academic requirements, and

FURTHER: That the Illinois State Medical Society request that the Governor of the State of Illinois appoint a separate Commission composed of practicing physicians, nurses, hospital administrators, and educators to regulate schools of nursing and to develop such a program.

Submitted by The Ford County Medical Society.

PAUL W. SUNDERLAND, M.D.
President.
ROSS A. HUTCHISON, M.D.
Secretary.

THE PRESIDENT: This will be referred to Reference Committee "E".

FORD COUNTY SOCIETY

WHEREAS: The Ford County Medical Advisory Committee to the County Department of the Illinois Public Aid Commission has pointed out the inequities of drug allowances to dispensing physicians compared to druggists' prescriptions, and

WHEREAS: The allowance for drugs of cost plus five per cent is unrealistic and detrimental to adequate medical care for the recipients, and

WHEREAS: The Commission's policy discourages dispensing and encourages prescribing and results in greater cost to the State of Illinois; therefore,

BE IT RESOLVED: That the Ford County Medical Society approve the Medical Advisory Committee's resignation and further resolve to withdraw its approval and support from the Illinois Public Aid program until the inequities shall be resolved.

Voted and approved April 26, 1955.

P. W. SUNDERLAND, M.D.
President.
ROSS N. HUTCHISON, M.D.
Secretary.

THE PRESIDENT: This resolution will be referred to Reference Committee "A".

Dr. Maurice Hoeltgen, Chicago, has several resolutions to present from the Council of the Chicago Medical Society.

1. *VISUAL CARE: FUNCTION OF OPHTHALMOLOGISTS OR OPTOMETRISTS?*

The Chicago Ophthalmological Society at its meeting of April 18, 1955, authorized its Legislation and and Economic Relations Committee to prepare the following resolution:

Whereas, the American Optometric Association at its annual convention at Seattle, Washington, June 20-22, 1954, resolved that the field of visual care is the field of optometry and should be exclusively the field of optometry, and

Whereas, there is pending in the State of Oklahoma House Bill No. 777 and Senate Bill No. 155 giving optometrists the right to make all tests and measurements for the discovery and/or diagnosis of glaucoma and other diseases or conditions of the eye,

Therefore be it resolved, that the Chicago Ophthalmological Society, in the interest of public welfare, preservation of eyesight and prevention of blindness, is unalterably opposed to being excluded from the field of visual care and to granting the optometrist the right to engage in the practice of medical ophthalmology.

DR. HOELTGEN: The Council of the Chicago Medical Society on May 3, 1955 adopted this resolution without a dissenting vote and directed that it be sent to the House of Delegates of the Illinois State Medical Society and to the Eye, Ear, Nose and Throat Section.

THE PRESIDENT: This resolution will be referred to the Reference Committee on Reports of Standing Committees, Dr. Whiting, Chairman.

2. *SCHOOL OF OPTOMETRY IN THE CHICAGO MEDICAL CENTER.*

Whereas, the American Optometric Association at its annual convention at Seattle, Washington, June 20-22, 1954, resolved that the field of visual care is the field of optometry and should be exclusively the field of optometry, and

Whereas, there is pending in the State of Oklahoma House Bill No. 777 and Senate Bill No. 155 giving optometrists the right to make all tests and measurements for the discovery and/or diagnosis of glaucoma and other diseases or conditions of the eye,

Resolved, that it is the opinion of the Council of the Chicago Medical Society that a School of Optometry should not be placed in the Chicago Medical Center and that this resolution should be presented to the Eye, Ear, Nose and Throat Section of the Illinois State Medical Society, and the House of Delegates of the Illinois State Medical Society.

DR. HOELTGEN: The Council of the Chicago Medical Society on May 3, 1955 adopted this resolution without a dissenting vote and directed that it be sent to the House of Delegates of the Illinois State Medical Society and to the Eye, Ear, Nose and Throat Section.

THE PRESIDENT: This resolution will be referred to the Reference Committee on Reports of Standing Committees, Dr. Whiting, Chairman.

3. *NON-PARTICIPATION OF ILLINOIS STATE MEDICAL SOCIETY IN THE INTERPROFESSIONAL COUNCIL*

Whereas, the American Optometric Association at its annual convention at Seattle, Washington, June 20-22, 1954, resolved that the field of visual care is the field of optometry and should be exclusively the field of optometry, and

Whereas, there is pending in the State of Oklahoma House Bill No. 777 and Senate Bill No. 155 giving optometrists the right to make all tests and measure-

ments for the discovery and/or diagnosis of glaucoma and other diseases or conditions of the eye,

Therefore, it is the opinion of the Council of the Chicago Medical Society that inasmuch as the American Optometric Association is very unfriendly to a segment of medicine, that the Illinois State Medical Society should not participate in the Interprofessional Council. Further, that this resolution be presented to the Eye, Ear, Nose and Throat Section of the Illinois State Medical Society and the House of Delegates of the Illinois State Medical Society.

DR. HOELTGEN: The Council of the Chicago Medical Society at its meeting on May 3, 1955 adopted this resolution without a dissenting vote and directed that it be sent to the House of Delegates of the Illinois State Medical Society and to the Eye, Ear, Nose and Throat Section.

THE PRESIDENT: This resolution will be referred to the Committee on Reports of Standing Committees, Dr. Whiting, Chairman.

4. *ENCROACHMENT OF DENTAL AND ORAL SURGICAL SPECIALTIES ON MEDICAL AND SURGICAL PRACTICE*

Whereas, the efforts of members of the dental and oral surgical specialties has resulted in an enroachment on disease entities of the oral cavities and associated structures in the practice of their surgical specialty,

Be it resolved, that we, as members of the Chicago Laryngological and Otological Society go on record as being unalterably opposed to this practice until the House of Delegates of the American Medical Association approves a properly worded resolution.

DR. HOELTGEN: The Council of the Chicago Medical Society at its meeting on May 3, 1955, adopted this resolution without a dissenting vote and directed that it be sent to the House of Delegates of the Illinois State Medical Society and to the Eye, Ear, Nose and Throat Section.

THE PRESIDENT: This resolution will be referred to the Reference Committee on Reports of Standing Committees, Dr. Whiting, Chairman.

5. *STANDARDS FOR THE DENTAL STAFF OF HOSPITALS*

Whereas, The Joint Commission on Accreditation of Hospitals on December 5, 1953 established standards for the dental staff of hospitals as follows:

"The dental staff shall conform in general to standards established for the medical staff (see Required 11). In addition:

1. Members of the dental staff shall be graduates of approved schools of dentistry.
2. Patients admitted for dental services shall be admitted on a surgical service and shall be the responsibility of the chief of that service.
3. Adequate medical survey, by a member of the service to which admitted, shall be done on each patient before dental surgery. Indicated consultations shall be held in complicated cases." and

Whereas, efforts are being made by members of the dental oral surgery profession to encompass all the disease entities of the oral cavity and its associated structures in the practice of their surgical specialty, and

Whereas, efforts are being made to interpret the standard established for the dental staff of a hospital by The Joint Commission on Accreditation of Hospitals as to permit treatment beyond the limits of the present established dental activities, and

Whereas, this would seem to be contrary to the patients' interest, and

Whereas, as the A.M.A. House of Delegates meeting in Miami, Florida a report was made defining oral dental surgery, which provoked extensive discussion and at that time, it was voted by the House of Delegates not to accept the present report. It was remanded that the Joint Committees be continued between the A.M.A. and the A.D.A. to work out a suitable definition and report back to the House of Delegates of the A.M.A.

Therefore, be it resolved, that the members of the Chicago Laryngological and Otological Society go on record as being unalterably opposed to any change in the standard as outlined by The Joint Commission on Accreditation of Hospitals governing the dental staff until the House of Delegates of the A.M.A. approves a properly worded definition and resolution.

DR. HOELTGEN: This resolution emanated from the Chicago Laryngological and Otological Society and was adopted by the Council of the Chicago Medical Society at its meeting on May 3, 1955 without a dissenting vote. The Council directed that it be sent to the House of Delegates of the Illinois State Medical Society and to the Eye, Ear, Nose and Throat Section.

THE PRESIDENT: This resolution will be referred to the Reference Committee on Reports of Standing Committees, Dr. Whiting, Chairman.

6. *FUNCTION OF THE WOMAN'S AUXILIARY*

Whereas, the auxiliaries function on three levels, namely the national, state, and county,

Whereas, the Illinois State Medical Society in its By-Laws, Chapter XI, Section 3, states: "Only one component medical society shall be chartered in any one county,"

Whereas, the Chicago Medical Society is the medical society of the county of Cook,

Whereas, Webster's Dictionary defines auxiliary as: serving in a subsidiary manner, helping, subservient, subordinate,

Therefore be it resolved, that the organization of auxiliaries to branches of the County Medical Society is the sole responsibility of the County Medical Society, its respective branch and its Woman's Auxiliary, and

Be it further resolved, that the Woman's Auxiliary to the Illinois State Medical Society be requested to make all contacts with the county medical society, and not with its branch auxiliaries. Urgent emergency contacts may be made directly to the branches, but the county auxiliary should be immediately notified of the action.

DR. HOELTGEN: This resolution originated in the Council of the Chicago Medical Society and was adopted without a dissenting vote on May 3, 1955. The Council directed that it be sent to the House of Delegates of the Illinois State Medical Society.

THE PRESIDENT: This resolution will be referred to the Reference Committee on Reports of Council Committees, Committee "B", Dr. Reavley, Chairman.

7. *METHOD OF ELECTING THE OFFICIAL REPRESENTATIVE FROM THE WOMAN'S AUXILIARY TO THE CHICAGO MEDICAL TO THE STATE AUXILIARY*

Whereas, 967 members of the 2,500 members of the Woman's Auxiliary to the Illinois State Medical Society are members of the Woman's Auxiliary to the Chicago Medical Society,

Whereas, the Woman's Auxiliary to the Chicago Medical Society has contributed more than one third of the total dues paid to the state, and more than half of the total contributed to the Benevolence Fund,

Whereas, Illinois ranks fiftieth in the list of states and territories with an A.M.A. to Woman's Auxiliary percentage of 24.6%,

Whereas, the Woman's Auxiliary should be one of

our strongest public relations potentials, and at present is practically unused,

Whereas, the auxiliary could be a strong legislative power,

Therefore be it resolved, that a fair and democratic method be established to name official representative from Woman's Auxiliary to the Chicago Medical Society to the State auxiliary. *This* should either follow the pattern of the Illinois State Medical Society, with a Downstate Caucus and a Chicago caucus during state convention, or be patterned after the Woman's Auxiliary to the American Medical Association.

DR. HOELTGEN: This resolution emanated from the Council of the Chicago Medical Society. The Council adopted this resolution without a dissenting vote at the meeting on May 3, 1955 and directed that it be sent to the House of Delegates of the Illinois State Medical Society.

THE PRESIDENT: This resolution will be referred to the Reference Committee on Reports of Council Committees, Committee "B", Dr. Reavley, Chairman.

8. *A MORE EQUITABLE REPRESENTATION FROM THE CHICAGO MEDICAL TO THE BOARD OF DIRECTORS OF THE STATE WOMAN'S AUXILIARY*

Whereas, 967 members of the 2,500 members of the Woman's Auxiliary to the Illinois State Medical Society are members of the Woman's Auxiliary to the Chicago Medical Society,

Whereas, the Woman's Auxiliary to the Chicago Medical Society has contributed more than one third of the total dues paid to the state, and more than half the total contributed to the Benevolence Fund,

Whereas, the Council of the Illinois State Medical Society is composed of 16 councilors, 6 of whom are from Chicago,

Whereas, the state board of directors of the State Woman's Auxiliary, which is analogous to the Council, is composed of 13 councilors, 3 of whom are from Chicago,

Therefore be it resolved, that a fair and reasonable method be established which will provide a representative participation from the Chicago Medical Society in an equitable proportion to the state auxiliary, similar to the representation existing at present in Council of the Illinois State Medical Society.

DR. HOELTGEN: This resolution also emanated from the Council of the Chicago Medical Society and was adopted by the Council at the meeting on May 3, 1955 without a dissenting vote. The Council directed that it be sent to the House of Delegates of the Illinois State Medical Society.

THE PRESIDENT: This resolution will be referred to the Reference Committee on Reports of Council Committees, Committee "B", Dr. Reavley, Chairman.

9. *PROFESSIONAL FEES AND SPECIAL PRIVILEGES TO INSURANCE COMPANIES*

Whereas, the practice of medicine is a personal professional service rendered by duly qualified and licensed physicians to individual patients, and

Whereas, ideally all relationships, including financial, between patients and the physicians of their own choice should remain confidential and not be surrendered to any third party, and

Whereas, the responsibility of the physician is to his patient rather than to any insurance company, plan or program, and

Whereas, the American Medical Association has on several occasions defined those services which properly constitute the practice of medicine, and

Whereas, at its 1949 session the House of Delegates of the American Medical Association adopted a statement to the effect that the American Medical Association is not engaged in the insurance business and has no intention of giving a preferential standing to any type of voluntary plan, and

Whereas, at the 1950 Clinic Session of the House of Delegates of the American Medical Association the following statement of principle was adopted:

> "It is the consensus of the Council (on Medical Service) that constituent State and Territorial Associations and component societies should endeavor to continue to improve the standard for all types of voluntary health insurance within their respective areas. The physician as well as the patient should be ever mindful of the true concept of voluntary health insurance which embraces the philosophy that such mechanisms are *aids* to the recipients of health care in the financing of such care."

and

Whereas, American tradition for years has firmly placed the responsibility for financing or the purchasing of services on the individual or family unit, and

Whereas, such definitions, principles and policies above referred to should not be altered or amended by policies or contracts of insurance organizations, regardless of their sponsors, and

Whereas, efforts are being made by different groups, including insurance companies and prepayment plans in various parts of the United States to effect preferential treatment of their particular members or subscribers and to grant franchises or privileges of a special nature, and

Whereas, to grant any preferential considerations or exclusive franchises to members of one group which are not available equally to all self-supporting segments of the population, whether insured or not insured, would not be in the public interest, now

Therefore be it resolved, that the Chicago Medical Society reaffirm the above actions of the House of Delegates of the American Medical Association as well as the action taken at the Clinical Session of said House in 1953 which condemned all insurance contracts which classified any medical service as a hospital service, and

Be it further resolved, that the Chicago Medical Society deems it improper and in violation of the public interest for the medical profession to grant any special or exclusive concessions to any one type of insurer or for any insurer to seek special consideration which would be exclusive to it,

Be it further resolved, that the Chicago Medical Society deems it improper, unprofessional and contrary to the public interest for any physician to increase his usual fees for professional services on the basis that his patient is entitled to insurance benefits, and

Be it finally resolved, that these resolutions be presented to the House of Delegates of the Illinois State Medical Society at the next annual meeting with the recommendation that they be adopted.

DR. HOELTGEN: This resolution emanated from the Council of the Chicago Medical Society. The Council, at its meeting on April 12, 1955, adopted this resolution without a dissenting vote and directed that it be sent to the House of Delegates of the Illinois State Medical Society, and that the Chicago Medical Society reaffirms the above action of the House of

Delegates of the American Medical Association.

THE PRESIDENT: This resolution will be referred to the Committee on Miscellaneous Business, Dr. Mauzey, Chairman.

Are there other resolutions?

The Chair recognizes Dr. Nicholas Balsamo of the West Side Branch of the Chicago Medical Society.

AUDIT OF BOOKS OF HOSPITAL STAFF MEMBERS FOR THE PURPOSE OF DETECTING FEE SPLITTING

Whereas, the House of Delegates of the American Medical Association in 1954, in response to a resolution from Illinois introduced in 1952, approved changes in the Code of Ethics designed to clarify billing procedures, and

Whereas, the Board of Trustees approved further study by a Committee on Medical Practices whose report now may be "The American Medical Association's proposed answer to the controversial and much publicized problem of fee-splitting", be it therefore

Resolved, that the Delegates from Illinois to the American Medical Association be urged to support this report particularly the following four recommendations:

"1. A subcommittee be created to work on a relative value scale such as those produced by the thoracic surgeons. This scale, based on points and not dollars, would apply to the whole of the practice of medicine and surgery. It would indicate the proper relation between fees for various medical and surgical specialties.

2. A program of public education by the A.M.A. Department of Public Relations on the value of a diagnostic and medical work be fostered to increase the public's appreciation of non-surgical work.

3. The American Medical Association encourages the various specialty boards in medicine to reappraise the value of their regulations restricting the practice to those seeking or holding board certificates.

4. The American Medical Association continue to discourage arbitrary restrictions by hospitals against general practitioners," *

and be it further

Resolved, that the Illinois State Medical Society urge the House of Delegates of the American Medical Association to ask the American Hospital Association to request that Boards of Trustees of Hospitals refrain from demanding that Medical Staff members submit to an audit of their books for the purpose of detecting fee-splitting and that the Hospital Association be given assurances that organized medicine is ready, willing, and able to satisfactorily solve its own problems, and be it further

Resolved, that after approval by the House of Delegates of the Illinois State Medical Society, this resolution in its entirety or in substance be forwarded to the House of Delegates of the American Medical Association.

THE PRESIDENT: This resolution will be referred to the Reference Committee on Miscellaneous Business, Dr. Mauzey, Chairman.

DR. HOMER D. JUNKIN, Paris: I have a resolution from Edgar County.

TRAINING SCHOOLS FOR NURSES

Whereas, The Champaign County Medical Society has submitted to this House of Delegates a resolution concerning the serious status of the nursing problem,

Whereas, the Society of Edgar County is familiar with the various statements made in the Champaign County Medical Society's resolution, and know them to be true and pertinent, inasmuch as the training school in Paris, Illinois was closed and the causes of this closing coincide with the same problems set forth by Champaign County,

Therefore be it resolved, that the Edgar County Medical Society go on record approving this resolution, and that serious consideration be given to this important resolution by this honorable body assembled.

(Signed) THE EDGAR COUNTY MEDICAL SOCIETY
Paul E. Fleener, M.D., President
W. W. Hoeffding, M.D., Secretary

THE PRESIDENT: This resolution will be referred to Committee "E", Dr. Wolff, Chairman.

Is there any further business to come before the House? The Chair recognizes Dr. Robert E. Hayes, Chicago.

DR. HAYES: I have resigned from all committees because of illness. I thank you for the opportunity of working with the House of Delegates for so many years.

THE PRESIDENT: Thank you Dr. Hayes.

If there is no further business I will entertain a motion for adjournment.

DR. MATHER PFEIFFENBERGER, Alton: I move we adjourn. (Motion seconded by Dr. Harry Mantz, Alton, and carried).

The House adjourned at 11:30 A.M. to meet again on Thursday, at 3:30 P.M.

*Quotations taken from American Medical Association Secretary's Letter, No. 324, May 5, 1955.

In The August Issue —

Second and Third Sessions of the House of Delegates and a Complete Picture Story of the Annual Meeting



Thank you doctor
for telling mother about...



The Best Tasting Aspirin you can prescribe

The Flavor Remains Stable down to the last tablet

Bottle of 24 tablets 15¢ (2½ grs. each)

We will be pleased to send samples on request

THE BAYER COMPANY DIVISION of Sterling Drug Inc., 1450 Broadway, New York 18, N.Y.

BOOK REVIEWS

PRINCIPLES OF INTERNAL MEDICINE. T. R. Harrison, William H. Resnik, Paul B. Beeson, George W. Thorn and M. M. Wintrobe, editors, Second edition. The Blakiston Company, Inc., New York. Student edition — one volume, $16.00. Professional edition — two volumes — $21.00.

The first edition of this popular book, published in 1950, had five printings between August 1950 and October, 1953. Eighty-five contributors were responsible for the development of the book, these being selected carefully by the editors. It was the desire of the editors to present material dealing with the practical problems in internal medicine today, and to integrate this with basic principles which will in all likelihood determine the medical practice of tomorrow.

There are most than 200 illustrations, with a number of plates in color which add materially to the interest in the book.

The book well covers the field of internal medicine, giving the important principles for a better understanding of the development, evolution and management of these many diseases. It is of value to both the student and to the practicing physician, the latter having a specific case in mind, can check carefully with the text and receive information which will be of value in the management of the case in mind.

The arrangement of the material in the book is unusual, yet arranged so well that it is possible for the perplexed physician to carefully study the symptoms of the patient as discussed in the book, then by a process of elimination, be aided materially in making the diagnosis. There are more than 1700 pages of text in the book, and a comprehensive index of nearly 90 pages. This book will be of advantage to any physician and should be in every modern medical library.

‹ ›

BOOKS RECEIVED

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

Hey Groves' Synopsis of Surgery. Fourteenth Edition. Illustrated. Edited by Sir Cecil Wakeley, Bt., K. B. E., C. B., LL. D. The Williams and Wilkins Company, Baltimore. $7.00.

Prolonged and Perplexing Fevers. By Chester S. Keefer, M. D., Physician-in-Chief and Director, Evans Memorial, Massachusetts Memorial Hospitals; Wade Professor of Medicine, Boston University School of Medicine and Samuel E. Leard, M. D., Assistant Visiting Physician and Assistant Member, Evans Memorial, Massachusetts Memorial Hospitals; Instructor in Medicine, Boston University School of Medicine. Little, Brown and Company, Boston, Toronto. $5.50.

Management of Addictions. Edited by Edward Podolsky, M. D., Department of Psychiatry, Kings County Hospital, Brooklyn, New York, Editor of "Music Therapy" and "War Medicine". Philosophical Library, New York. $7.50.

Heart Disease — Its Diagnosis and Treatment. By Emanuel Goldberger, M. D., F. A. C. P. Associate Attending Physician, Montefiore Hospital, New York; Cardiologist and Attending Physician, Lincoln Hospital, New York; Lecturer in Medicine, Columbia University. Second Edition. 781 pages. 298 illustration on 107 figures. 5 tables. Lea & Febiger, Philadelphia 6, Pa. $12.50.

Practical Medical Mycology. By Edmund L. Keeney, A. B., M. D., Formerly: In Charge of Mycology Laboratory, Visiting Physician and Dispensary Physician (Allergy) The Johns Hopkins Hospital,

(*Continued on page* 56)



DOCTOR, here's a question and an answer you may find useful when patients ask about cigarettes:

What do Viceroys do for you that no other filter tip can do?



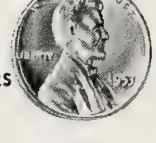
These filter traps, doctor, are composed of a pure white non-mineral cellulose acetate. They provide maximum filtering efficiency without affecting the flow of the smoke.

And, in addition, they enhance the flavor of Viceroy's quality tobaccos to such a degree that smokers report they taste even better than cigarettes without filters.

King-Size Filter Tip **VICEROY**

WORLD'S MOST POPULAR FILTER TIP CIGARETTE

ONLY A PENNY OR TWO MORE THAN CIGARETTES WITHOUT FILTERS





BOOKS RECEIVED (Continued)

Instructor in Medicine, The Johns Hopkins University School of Medicine, Fellow, American College of Physicians, Fellow, American Academy of Allergy, Member, Western Society for Clinical Research, Member, American Society for Clinical Investigation, San Diego, California. Charles C. Thomas, Springfield, Illinois, Publisher. $4.50.

SHOULD THE PATIENT KNOW THE TRUTH? A response of physicians, nurses, clergymen, and lawyers. Edited by Samuel Standard, M. D., and Helmuth Nathan, M. D., Springer Publishing Company, Inc., New York. $3.00 hard cover, $2.00 soft cover.

LEUKOCYTIC FUNCTIONS. Annals of the New York Academy of Sciences. Volume 59, Art. 5, pages 665-1070. Roy Waldo Miner, Editor. Albert S. Gordon, Consulting Editor. 406 pages, illustrated. $4.50.

1955 MEDICAL PROGRESS — A Review of Medical Advances During 1954. Morris Fishbein, M. D. Editor. The Blakiston Division, McGraw-Hill Book Company, Inc., New York, Toronto and London. $5.50.

KINESIOLOGY OF THE HUMAN BODY — Under Normal and Pathological Conditions. By Arthur Steindler, M. D., Eng. F. A. C. S., F. I. C. S., (Hon) F. R. C. S., Professor of Orthopedic Surgery Emeritus, State University of Iowa, Head of Orthopedic Department, Mercy Hospital, Iowa City, Iowa. Charles C. Thomas, Publisher, Springfield, Illinois. $19.75.

PAIN — Its Mechanisms and Neurosurgical Control. By James C. White, M. D., F. A. C. S., Chief of Neurosurgical Service, Massachusetts General Hospital, Associate Professor of Surgery, Harvard Medical School and William H. Sweet, M. D., F. A. C. S., Associate Visiting Neurosurgeon, Massachusetts General Hospital, Associate Clinical Professor of Surgery, Harvard Medical School. Charles C. Thomas, Publisher, Springfield, Illinois. $17.50.

BICKHAM-CALLANDER SURGERY OF THE ALIMENTARY TRACT. Volumes 1, 11 and 111. By Richard T. Shackelford, M. D., Assistant Professor of Surgery, Johns Hopkins, University School of Medicine. Assisted by Hammond J. Dugan, M. D. Assistant in Surgery, Johns Hopkins University School of Medicine. W. B. Saunders Company, Philadelphia and London. $60.00 per set.

CLINICAL ENDOCRINOLOGY—For Practitioners and Students. By Laurence Martin, M.D., F.R.C.P., Physician to Addenbrooke's Hospital, Cambridge, Assessor to the Regis Professor of Physics, University of Cambridge, and Martin Hynes, M.D., M.R.C.P.,

(*Continued on page* 58)

Lederle

GRAVIDOX*

Pyridoxine-Thiamine *Lederle*

For preventing and treating nausea and vomiting of pregnancy

Pyridoxine (B_6) and Thiamine (B_1) have proved more effective in combination than either alone in the prevention and treatment of hyperemesis gravidarum. GRAVIDOX, in tablet and parenteral form, combines these vitamins, providing a nutritional approach to the problem. GRAVIDOX may also be useful for the prevention and relief of nausea and vomiting associated with radiation sickness.

Each GRAVIDOX tablet contains: Thiamine HCl—20 mg., Pyridoxine HCl—20 mg. Each cc. of GRAVIDOX parenteral solution contains: Thiamine HCl—50 mg., Pyridoxine HCl—50 mg.

Average dose: 5 to 12 tablets daily, in divided doses, at times when vomiting is less likely to occur; or 1 cc. parenteral solution 2 or 3 times weekly.

LEDERLE LABORATORIES DIVISION AMERICAN Cyanamid COMPANY Pearl River, New York

*REG. U. S. PAT. OFF.

unexcelled among sulfa drugs

for highest potency • wide spectrum • highest blood, plasma & tissue levels • safety* • minimal side effects • economy

*Valid tests, clinical trials, and long use prove that the Triple Sulfas offer greater relative safety than any single sulfa, and that they compare favorably with any potent therapeutic agent in their relative freedom from toxic side effects. Besides their considerable safety, the Triple Sulfas are distinguished by their established efficacy, broad-spectrum activity, and outstanding economy. Their use increases daily.

Triple Sulfas, alone or in combination with certain other agents, are available from leading pharmaceutical manufacturers under their own brand names. This message is presented in their behalf.



All sulfas are not Triple Sulfas!

ASK ANY MEDICAL REPRESENTATIVE ABOUT THE TRIPLE SULFA PRODUCTS HIS COMPANY OFFERS

Cyanamid Fine Chemicals

AMERICAN Cyanamid COMPANY

FINE CHEMICALS DIVISION

30 ROCKEFELLER PLAZA, NEW YORK 20, N. Y.

BOOKS RECEIVED (Continued)

Clinical Pathologist to the Royal Northern Group of Hospitals, lately Reader in Medicine in the University of Cambridge. Foreword by Sir Lionel Whitby. Second edition. 39 illustrations. Little, Brown and Company, Boston, 1954. $5.50.

BEDSIDE DIAGNOSIS. By Charles Seward, M.D., F.R.C.P. Foreword by Sir Henry Cohen. Third edition. E. & S. Livingstone, Ltd., Edinburgh and London, 1955. $4.00.

THE BIOLOGIC EFFECTS OF TOBACCO—with emphasis on the clinical and experimental aspects. Edited by Ernest L. Wynder, M.D., Head, Section of Epidemiology, and Associate, Sloan-Kettering Institute for Cancer Research. Foreword by Joseph Garland, M.D., Editor, The New England Journal of Medicine. Little, Brown and Company, Boston, Toronto. $4.50.

PSYCHIATRY FOR THE FAMILY PHYSICIAN. By C. Knight Aldrich, M.D., Associate Professor of Psychiatry, University of Minnesota Medical School. The Blakiston Division, McGraw-Hill Book Company, Inc., New York, Toronto and London. $5.75.

GYNAECOLOGY. Fifth edition. By Douglas H. Macleod, M.S., F.R.C.P., F.R.C.S., F.R.C.O.G., and Charles D. Read, M.B., F.R.C.S., F.R.A.C.S., F.R.C.O.G., 551 illustrations; 27 in color. Little, Brown and Company, Boston, Toronto. $16.00.

INTERNATIONAL SYMPOSIUM. THE HYPOPHYSEAL GROWTH HORMONE, NATURE AND ACTIONS. Editors—Richmond W. Smith, Jr., M.D., Physician-in-Charge, Division of Endocrinology, Henry Ford Hospital, Detroit, and Oliver H. Gaebler, M.D., Head, Biochemistry Department, Edsel B. Ford Institute for Medical Research, Detroit, and C. N. H. Long, M.D., Sterling Professor of Physiology, Yale University School of Medicine, New Haven. The Blakiston Division, McGraw-Hill Book Company, Inc., New York, Toronto, London. $12.00.

PERINATAL MORTALITY IN NEW YORK CITY—Responsible Factors. A study of 955 deaths by The Subcommittee on Neonatal Mortality, Committee on Public Health Relations, The New York Academy of Medicine, Analyzed and Reported by Schuyler G. Kohl, M.S., M.D., Dr. P. H. Published for The Commonwealth Fund by Harvard University Press, Cambridge, Massachusetts, 1955. $2.50.

MINOR SURGERY. By John E. Sutton, M.D., F.A.C.S., Assistant Clinical Professor of Surgery, Cornell University, Medical College, Diplomate American Board of Surgery. Over 100 illustrations. Landsberger Medical Books, Inc. Distributed solely by The Blakiston Division of the McGraw-Hill Book Company with the exception of Continental Europe. $7.00.

METICORTEN

PREDNISONE (metacortandracin)

Schering

more potent than cortisone
or hydrocortisone · devoid of
major undesirable side effects

*T.M.

METICORTEN,* brand of prednisone.

PICKER announces the



natomatic Century II

diagnostic x-ray unit

with "dial-the-part" Automation

at an "easy-on-the-purse" price!

's called "Anatomatic"

ramatically simple automation of radiographic control which,
en in unskilled hands, closely approaches the goal of
a good picture every time."

o charts, no calculations

utomatically sets up optimum technic the instant you "dial-the-part" . . .
s possible to make good radiographs with it *without even knowing the eaning* of kilovoltage and milliamperage.

ll you do is . . .

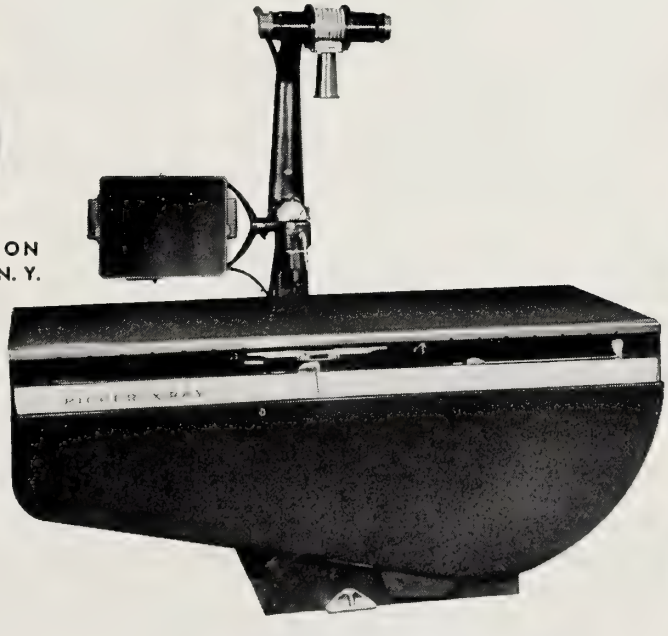
a) Dial the body part on a part-selector scale
b) set its measured thickness on another scale
c) press the exposure button.

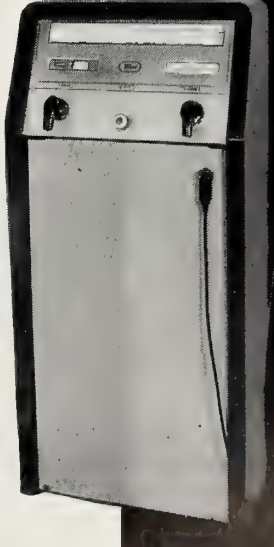
nd a new table that's a joy to use

n advanced x-ray table that combines long-famed Century
se-of-operation with a new "forward look" that fairly breathes prestige.

Picker x-ray

CKER X-RAY CORPORATION
South Broadway, White Plains, N. Y.





et the story from your local Picker representative

AGO 7, ILL., 1010 West Jackson Blvd. KANKAKEE, ILL., 868 S. Schuyler Avenue
KFORD, ILL., 209 Warren Avenue PEORIA, ILL., 301 S. Adams Street

new way in x-ray

specify

LEDERLE

POLIOMYELITIS IMMUNE GLOBULIN

(human)

Lederle

For the modification of measles and the prevention or attenuation of infectious hepatitis and poliomyelitis.

LEDERLE LABORATORIES DIVISION

AMERICAN Cyanamid COMPANY Pearl River, New York

Periodic examinations

By H. Corwin Hinshaw, M.D., Bulletin, National Tuberculosis Association, January, 1955.

The purpose of periodic examinations of persons in apparent good health is identical with that of other medical examinations: to detect disease in its earliest phases of development and to counsel persons in matters of health preservation.

Who should be examined? The more important a person is to society, to relatives and dependents or the business associates, the more important his health becomes. Key men in business, mothers of children, heads of families and those with other important missions to perform must conserve their productive capacity. Disability from preventable illness constitutes a serious threat to successful attainment of goals in life.

Many corporations regard the health of their executives as valuable assets to be conserved. Often they require executives to undergo periodic examinations at intervals of from six to twelve months, the expense being borne by the corporation. Labor unions look to the welfare of their

(*Continued on page 62*)

Back to first principles for REAL BREAD

The makers of Pepperidge Farm Bread believe in fresh natural ingredients for nutritionally valuable and taste-pleasing bread.

So the flour for our Whole Wheat Bread is stone-ground in our own grist mills—contains the wheat germ and all the natural goodness of the whole grain. And we use whole milk, sweet cream butter, yeast and unsulphured molasses to make our bread.

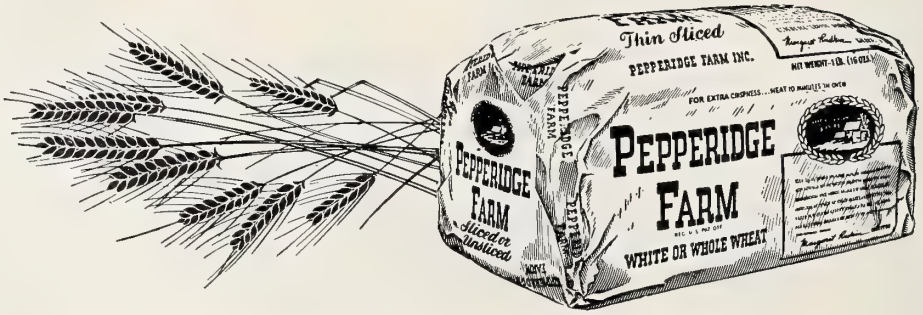
We offer White Bread, too—made with *unbleached* flour, dairy-fresh ingredients.

We suggest that Pepperidge Farm Bread deserves a place on your table.

For information about our special SALT-FREE Bread, please write to me.

Margaret Rudkin

DIRECTOR



PEPPERIDGE FARM BREAD

NORWALK, CONNECTICUT

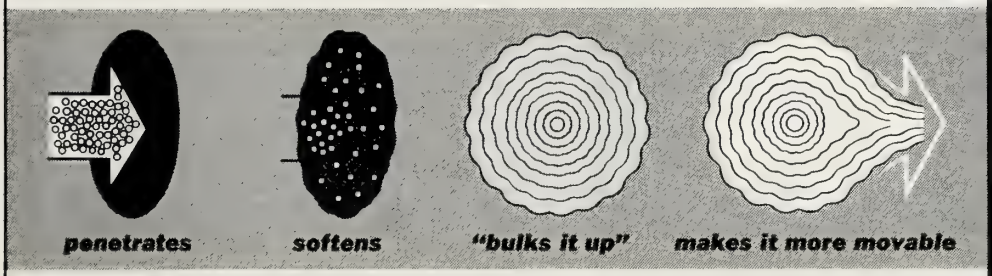
Each microscopic oil globule is encased in a tough, film of Irish moss for perfect emulsification and complete mixing with the stool.



KONDREMUL®

(PATCH)

a *penetrant* emulsion for chronic constipation



KONDREMUL (Plain)—Colloidal emulsion of mineral oil and Irish moss...pleasant-tasting and non-habit-forming. Contains 55% mineral oil. Supplied in bottles of 1 pt.

KONDREMUL WITH CASCARA— 0.66 Gm. nonbitter Ext. Cascara per tablespoon. Bottles of 14 fl.oz.

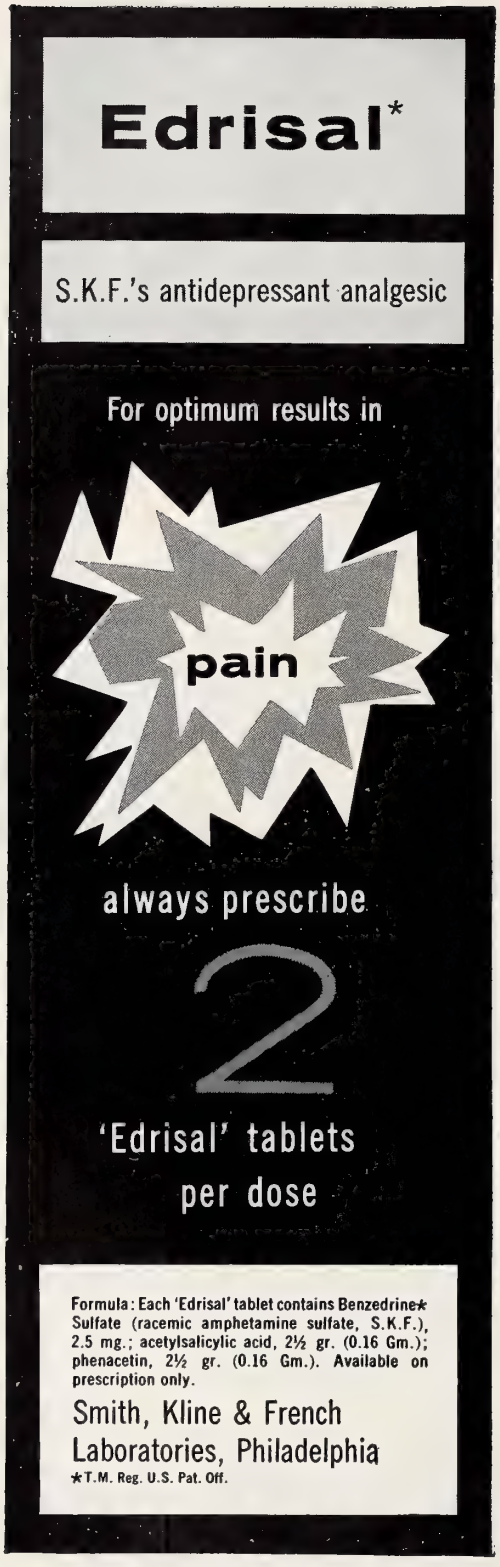
KONDREMUL WITH PHENOLPHTHALEIN — 0.13 Gm. (2.2 gr.) phenolphthalein per tablespoon. Bottles of 1 pt.

When taken as directed before retiring, KONDREMUL does not interfere with absorption of essential nutrients.

patch

THE E. L. PATCH COMPANY
STONEHAM, MASSACHUSETTS

KONDREMUL® (PATCH)



EXAMINATIONS (Continued)

members but few have come to recognize the need for examinations of the type advocated here. Physicians, who bear grave responsibilities to many people, are notably negligent of their own health, often because they fear to impose upon busy colleagues.

Persons with a history of chronic or recurring ailments, notably diabetes, tuberculosis, hypertension, duodenal ulcer, and other conditions have learned by experience that medical care is part of personal maintenance.

EXAMINATION TECHNIQUE

Many physicians have learned that the examination of persons who believe themselves to be well is no simple task. The skill and judgment required is at least equal to that needed for the care of the sick. The procedure of conducting an examination should be similar to that ordinarily employed when the subject is known to be ill.

A thorough medical history, interpreted by a physician with a broad knowledge of internal medicine, may yield clues to health hazards not previously recognized. A careful record of past ailments is secured, with emphasis upon conditions which tend to persist or recur. Often the past medical history must be supplemented later with clinical and laboratory records, X-ray films and the findings and opinions of previous physicians. The patient's recollections and his current opinions concerning previous illness may be faulty.

If the patient has noted any abnormality of function or volunteers any symptom, or if he expresses any special fear of disease, these are recorded in detail. Finally, specific questions are asked with respect to each organ system. The end result is a complete and orderly inventory of the functional status of all parts of the body insofar as these have appeared to the patient.

The physician should probe into the emotional problems and occupational strains which may relate to health and happiness. It is important to record habits of eating, sleeping, and recreation, as well as the nature and intensity of physical and mental effort expended in occupational pursuits. The consumption of alcohol, tobacco, sedatives, and self-prescribed medications should be estimated in quantitative terms. Often it is wise to inquire directly concerning sexual habits

(*Continued on page* 64)

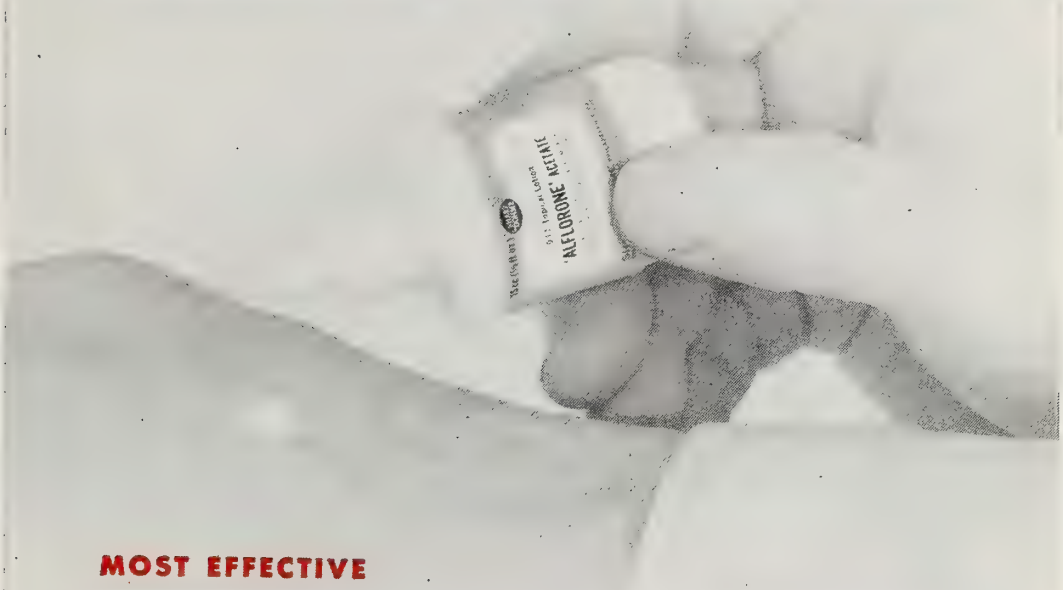
NEW- IN THE TOPICAL TREATMENT OF ALLERGIC SKIN CONDITIONS

TOPICAL LOTION

'ALFLORONE'

ACETATE

(FLUDROCORTISONE ACETATE, MERCK) 9 ALPHA-FLUOROHYDROCORTISONE ACETATE



MOST EFFECTIVE

Therapeutically active in 1/10th the concentration of hydrocortisone (Compound F).

MOST ECONOMICAL

Superior spreading qualities—a small quantity covers a wide area.

MOST ACCEPTABLE

Most patients prefer the cosmetic advantages of this easy-to-apply, smooth spreading lotion.

Supplied in a cosmetically elegant base in two concentrations: 0.25% and 0.1% in 15 cc. plastic squeeze bottles.

Also available: Alflorone Topical Ointment in 5 gm. tubes—two concentrations—0.25% and 0.1%.

SHARP & DOHME

Philadelphia 1, Pa.
DIVISION OF MERCK & CO., INC.

WEIGHT FOR WEIGHT, THE MOST EFFECTIVE ANTI-INFLAMMATORY AGENT YET DEVELOPED FOR TOPICAL USE

EXAMINATIONS (Continued)

and marital problems. Many persons who would never open such topics of conversation are eager to share their problems with an understanding physician and are benefited by doing so.

The physician should know his patient's ambitions, accomplishments, and plans for the future as well as his frustrations and failures. The physician, like the minister and the lawyer, is often in a position to assist the patient in anlyzing his life program.

Physical examination of the apparently well person must be fully as meticulous and complete as in the case of the ailing person. Minor deviations from normality are evaluated as possible incipient disease. All accessible structures are observed closely and examined with seeing hands. The actions of the heart and lungs are determined by traditional methods of physical examination. If blood pressure is elevated it is determined repeatedly until a base level is recorded. The body orifices, including the ocular fundus, the nasal and oral cavities, the rectum and vagina are examined visually and probed with examining fingers or instruments.

Laboratory and X-ray studies will be planned after the medical history and physical examination have been completed. Each test will be chosen to answer a specific question, often a question which arose as a result of the interview or examination. In addition to the special tests certain routine examinations are necessary. An X-ray examination of the lungs and heart is essential to all cases. Blood counts and urine analysis also may reveal conditions not producing symptoms or findings. Very few cases are found by the routine serologic test for syphilitic infection but it has become tradional. Electrocardiograms are indicated if the patient is over the age of forty-five years. Even a normal tracing may become valuable for purposes of comparison if cardiac disease appears later.

The success of some community-wide antituberculosis X-ray screening programs has suggested that tests to detect other diseases should be devised and applied to large population groups.

(*Continued on page* 68)

Theocalcin

brand of theobromine-calcium salicylate

For continuous, mild Cardiotonic and Diuretic Therapy

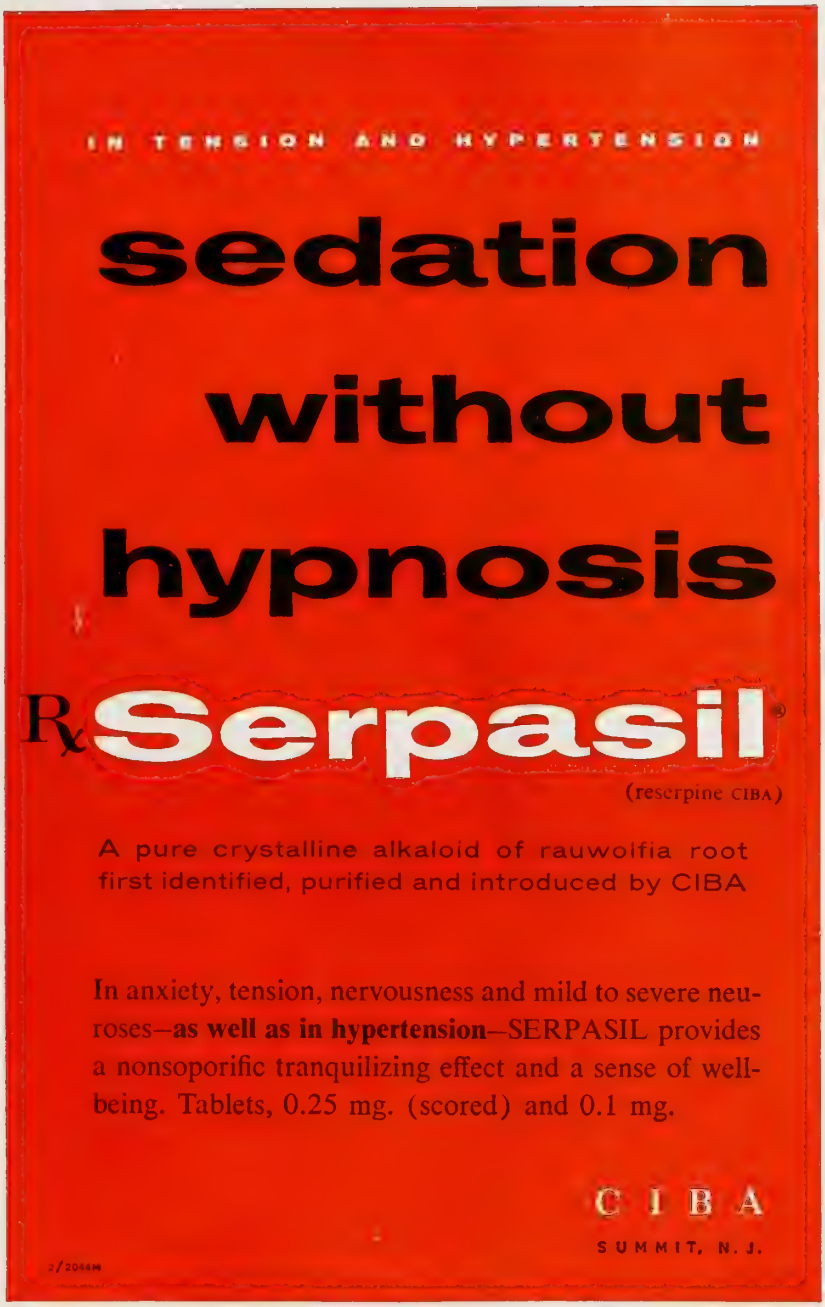
- for myocardial stimulation
- to diminish dyspnea
- to reduce edema

Prescribe THEOCALCIN — Start with 2 or 3 tablets 3 times a day and reduce the dose as improvement is obtained. Eventually the patient may be kept comfortable on a small maintenance dose of 1 or 2 tablets a day, several times a week.

Theocalcin®, a product of E. Bilhuber, Inc.

BILHUBER-KNOLL CORP. *distributor*

ORANGE
NEW JERSEY



New! SERPASIL® ELIXIR
Each 4-ml. teaspoonful contains 0.2 mg. of Serpasil

METICORTEN
PREDNISONE (metacortandracin)
more potent than cortisone or hydrocortisone • devoid of major undesirable side effects
SCHERING
Schering
*T.M.
METICORTEN,* brand of prednisone.

EXAMINATIONS (Continued)

many physicians and public health experts are opposed to such multiphasic screening programs except as research projects. The reasons for such opposition are obvious if comparisons are made between the requirements of a thorough examination and those of a series of simple laboratory tests. An easy and inexpensive way to make everybody healthy has not been found.

The National Tuberculosis Association and its affiliated health organizations can do much to popularize good and thorough periodic medical examinations. The problem is largely one of health education and medical economics. People have already learned that periodic dental examinations are wise and economical. Parents have already learned to consult pediatricians for advice and care of well children. When private pediatricians cannot be had, well baby clinics are provided. Why not well papa and well mamma clinics?

The actual cost of periodic health examinations by private physicians is not beyond the reach of the average working man. Maintenance of a man costs less than maintenance of an automobile. The cost of trading the serviceable old car for a new model is greater than the cost of a major illness. The cost of maintaining a good sickness insurance policy is less than the cost of smoking a package of cigarettes daily. Women spend more in beauty parlors than in doctors' offices. Many families who spend hundreds of dollars annually on luxuries and vices are considered to be "medically indigent." Values and standards are distorted through ignorance and improvidence.

Readers of popular magazines learn much about modern medicine, much that is true and some that is half true. Our elementary and secondary schools should now have organized courses in medical science, teaching anatomy, physiology and pathology. Such knowledge in the next generation would lead to better appreciation of health and good medical care. Money now spent on nostrums and quacks would be devoted to the purchase of adequate preventive and curative medical care.

The voluntary health organizations are the most potent factors in health education in America today. Their support should be directed toward securing the best medical care for well people as well as for persons who are ill.

For prolonged,

uninterrupted sedation

—all day or all night—

with only one oral dose

prescribe

ESKABARB*

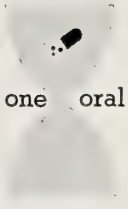
phenobarbital

SPANSULE*

brand of sustained release capsules

1 gr. & 1½ gr.

The modern, more effective
presentation of phenobarbital
particularly indicated in:
restlessness or irritability
nervousness
hypertension
insomnia
tension
epilepsy



only one oral dose

made only by

Smith, Kline & French
Laboratories, Philadelphia

first in sustained release oral medication

*T.M. Reg. U.S. Pat. Off. Patent Applied For.



WE CORDIALLY INVITE YOUR INQUIRY for application for membership which affords protection against loss of income from accident and sickness (accidental death, too) as well as benefits for hospital expenses for you and all your dependents.



SINCE 1902

ALL PREMIUMS COME FROM PHYSICIANS SURGEONS DENTISTS

ALL BENEFITS GO TO

$4,500,000 ASSETS
$22,500,000 PAID FOR BENEFITS

PHYSICIANS CASUALTY AND HEALTH ASSOCIATIONS
OMAHA 2, NEBRASKA

Surgery in acute cholecystitis

At present, my policy is to recommend immediate operation (in acute cholecystitis) if the patient is seen within 48 to 72 hours after onset of symptoms. If he is seen later than 72 hours after onset, I usually advise conservative therapy unless indications for an emergency operation develop. If the clinician watches the patient carefully, he can nearly always prevent development of the serious complications which so often lead to fatality. During this period of observation, three or four features must be observed constantly. If the patient's pain fails to disappear after 24 to 48 hours of good therapy, there is a strong likelihood that empyema or gangrene is developing. This possibility is still more likely if fever develops or increases with exacerbation of severe pain. If high fever develops or does not subside in 24 to 36 hours of active treatment likewise suspect empyema or gangrene. The development of severe rigidity or failure of regression after 24 to 36 hours' active treatment is usually indicative of a surgical lesion. Actually, if any of these three situations develops, immediate operation may be indicated to prevent perforation of the gall bladder or a fulminating infection. *Warren H. Cole, M.D. Acute Cholecystitis. Mississippi Valley M.J. May* 1955.

Nothing new

The competition between grocer and pharmacist is not new. The pharmacists of Nuremburg in 1581 explained their plight as follows: "The sale of all confections, formerly dispensed by us, has now fallen into the hands of the sugar dealer. Counter sales are now made by all the large spice and cheap grocery shops, thus robbing the druggist of a source of profit that he is justly entitled to. All distilled waters, oils, and the like, are now indiscriminately sold by any ignoramus who imagines himself qualified to engage in this traffic." The German pharmacists also placed part of the blame for the loss of patronage on the physician. "They, for instance, prescribe in German, so that any barber or old woman can prepare the medicine, and the druggist is ignored." *Joseph A. Zapotocky, Ph.D. The Same Old Story. Arizona Med. March* 1955.

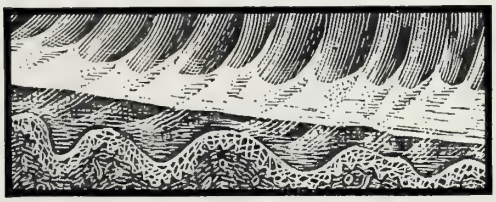
THOROUGH PENETRATION WITH VAGISEC COMBATS

JELLY AND LIQUID

FLARE-UPS

OF VAGINAL TRICHOMONIASIS

VAGISEC liquid is the new trichomonacide that explodes trichomonads within 15 seconds. It is a unique combination of three surface-acting chemicals which penetrates to hidden trichomonads and eliminates failure of treatment and flare-ups due to lack of penetration.



VAGISEC liquid penetrates to trichomonads buried among the vaginal rugae and imbedded in mucus and desquamated cells.

Hidden trichomonads. Trichomonads do not exist in the vaginal secretion alone. They are vigorously motile and burrow deeply into the surface of the vaginal mucosa where cellular debris and mucus cover them. VAGISEC liquid lowers surface tension, penetrates the cellular debris and dissolves mucoid material[1,2] that lines the vaginal wall and lies buried among the rugae. It reaches and explodes hidden as well as surface trichomonads.

Unique synergistic action. VAGISEC liquid combines a chelating agent to complex and remove the trichomonad's calcium, a wetting agent to remove its lipid material, and a detergent to denature its proteins. The trichomonad swells up and explodes. *No other agent or combination of agents kills the trichomonad in this specific fashion, or with this speed.*

Trichomonads explode within 15 seconds. "Motion pictures taken through a phase-contrast microscope at 24 frames per second show that individual trichomonads are destroyed within 10 to 14 seconds after contact with a 1:250 dilution."[3]

The Davis technic. The remarkable speed and unique synergistic action of this new trichomonacide are the result of the intensive research of its originators, Dr. Carl Henry Davis, well-known gynecologist and author and C. G. Grand, research physiologist, who introduced the agent as "Carlendacide" and had it clinically tested by over 100 leaders in obstetrics and gynecology. "Those who have followed the plan of treatment as closely as possible, have had better than 80 per cent of cures among non-pregnant patients with one course of treatment."[3] For "the small percentage of women who have an involvement of cervical, vestibular or urethral glands, other treatments will be required."[3]

Office treatment. Expose vagina with speculum. Wipe walls dry with cotton sponges and wash thoroughly for about three minutes with a 1:250 dilution of VAGISEC liquid. Remove excess fluid with cotton sponges. Office treatments are an integral part of the Davis technic.

Home treatment. Prescribe both VAGISEC jelly and VAGISEC liquid for home treatment. Patient inserts VAGISEC jelly each night and douches with VAGISEC liquid (1 teaspoonful to a quart of warm water) each morning, except on office treatment days. (Standard douche bag holds 2 quarts.)

Summary. VAGISEC liquid penetrates to hidden trichomonads and explodes them in 15 seconds. VAGISEC jelly and liquid are non-toxic and non-irritating, leave no messy discharge or staining. The Davis technic is a triple combination of 1) VAGISEC liquid in office treatment; 2) home treatment with VAGISEC jelly at night and 3) douche with VAGISEC liquid in the morning. VAGISEC jelly and liquid have been clinically tested and proved a remarkably fast-acting, effective treatment for vaginal trichomoniasis. Because of greater penetration, this therapy results in fewer flare-ups.

1. Davis, C.H.: Am. J. Obst. & Gynec. *68*:559 (Aug.) 1954.
2. Davis, C.H.: West. Jour. Surg. *63*:53 (Feb.) 1955.
3. Davis, C.H.: J.A.M.A. *157*:126 (Jan. 8) 1955.

VAGISEC IS THE TRADE-MARK OF JULIUS SCHMID, INC., FOR PRODUCTS TO BE USED IN THE CONTROL OF VAGINAL TRICHOMONIASIS

JULIUS SCHMID, INC., *gynecological division*

423 West 55th Street, New York 19, N. Y.

for CHILDREN with EDUCATIONAL and ADJUSTMENT PROBLEMS

. . . a private resident school for children of average or superior intelligence whose psychological difficulties impair their learning abilities and school progress.

. . . enrolling children from seven to fourteen years of age. Coeducational. Small classes. Remedial reading. Brochure on request.

. . . provides a program of education with psychotherapy.

. . . out-patient psychiatric evaluation and consultation for children.

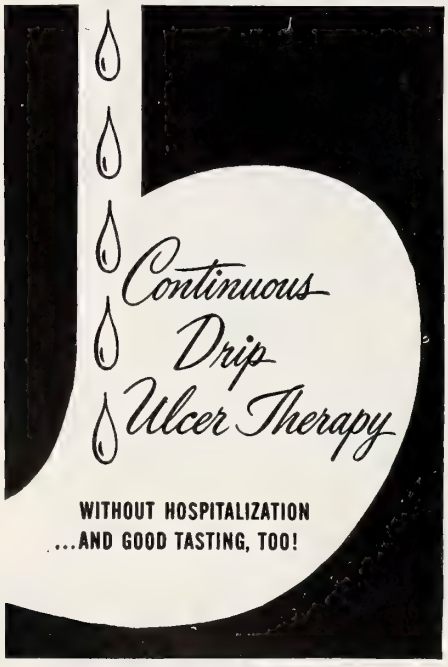
ANN ARBOR SCHOOL

A. H. Kambly M.D., Director

411 First National Building Ann Arbor, Mich.

Malignant surgery

Surgical attacks on highly malignant tumors, like trauma to streptococcal infections, may do more harm than good. They break the natural barriers. They spread the disease. When we remember that the blood and lymphatic vessels of highly malignant tumors are filled with tumor cells, it is clear that it is not often possible to excise such tumors completely. They have extended diffusely into the tissue spaces. They are systemic diseases. In cases of such tumors, the people who think that surgery does harm are right. Even when these cancers are detected early, even when they are treated by operations of the most radical scope, the disease is rarely checked by surgery. Tissue spaces are opened. Cancer cells gain further access to blood vessels and lymphatics. Cancer cells are seeded in the incision and in the peritoneal cavity. When the tumor is spreading diffusely, it is best to leave it alone. *George Crile, Jr., M.D. Common Sense in Cancer. Postgrad. Med. April* 1955.



HORLICKS CORPORATION
Pharmaceutical Division
RACINE, WISCONSIN

Nulacin

A recent clinical study* of 46 ambulatory nonhospital patients treated with Nulacin† and followed up to 15 months describes the value of ambulatory continuous drip therapy by this method. Total relief of symptoms was afforded to 44 of 46 patients with duodenal ulcer, gastric ulcer and hypertrophic gastritis.

The delicately flavored tablets dissolve slowly in the mouth (not to be chewed or swallowed). They are not noticeable and do not interfere with speech.

Nulacin tablets are supplied in tubes of 25 at all pharmacies. Physicians are invited to send for reprints and clinical sample.

*Steigmann, F., and Goldberg, E.: Ambulatory Continuous Drip Method in the Treatment of Peptic Ulcer, Am. J. Digest. Dis. *22*:67 (Mar.) 1955.

†Mg trisilicate 3.5 gr.; Ca carbonate 2.0 gr.; Mg oxide 2.0 gr.; Mg carbonate 0.5 gr.



for hay fever patients



preserve summer pleasures with these advantages

- unusually rapid relief
- outstanding freedom from side effects
- maximum convenience

the greatest variety of oral forms

CHLOR-TRIMETON REPETABS, 8 mg.
up to 12 hours of uninterrupted relief reported with just one dose

CHLOR-TRIMETON REPETABS, 12 mg.
for prolonged therapy in more difficult cases

CHLOR-TRIMETON Tablets, 4 mg.
for initiating therapy, maintenance therapy or adjusting dosage

CHLOR-TRIMETON REPETABS with Sodium Pentobarbital,
¾ gr. for nightlong relief and assured sleep

CHLOR-TRIMETON Syrup, 2 mg. per 4 cc.
palatable, compatible liquid

CHLOR-TRIMETON® maleate, brand of chlorprophenpyridamine maleate.
REPETABS,® Repeat Action Tablets.

SCHERING

CT-J-56

Foot-so-Port Shoe Construction and its Relation to Weight Distribution



- Insole extension and wedge at inner corner of heel where support is most needed.
- Special Supreme rubber heels are longer than most anatomic heels and maintain the appearance of normal shoes.
- The patented arch support construction is guaranteed not to break down.
- Innersoles are guaranteed not to crack, curl, or collapse. Insulated by a special layer of Texon which also cushions firmly and uniformly.
- Foot-so-Port lasts were designed and the shoe construction engineered with orthopedic advice.
- Over nine million pairs of men's,women's and children's Foot-so-Port Shoes have been sold.
- By a special process, using plastic positive casts of feet, we make more custom shoes for polio, club feet and all types of abnormal feet than any other manufacturer.

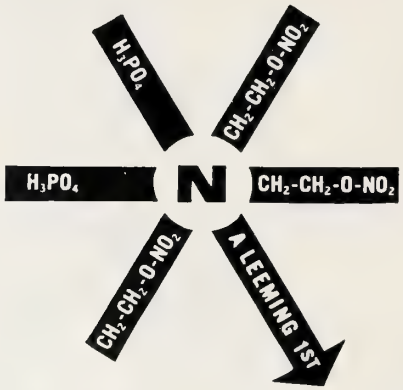
Write for details or contact your local **FOOT-SO-PORT** *Shoe Agency. Refer to your Classified Directory*

Foot-so-Port Shoe Company, Oconomowoc, Wis.

The hemiplegic walks again

No matter how severe the hemiplegia may be, every patient can be rehabilitated to walk provided he has a clear sensorium and has the will to do so. In many, bracing is essential. The amount and type of bracing will depend upon the degree of paralysis which can be assessed in most patients following the initial muscle examination and a trial at ambulation in parallel bars. Left to his own powers, the typical patient walks with an extended knee and circumducts his extremity in placing his foot in a forward position. The circumduction gait is used because flexion of the hip and knee put the foot automatically in plantar flexion and inversion. Since he is afraid to have his foot buckle under and fall, he soon learns that for security in walking he must keep the knee extended. The circumduction gait is inefficient and laborious and once it becomes established, correction becomes difficult. *Louis N. Rudin, M.D. Physical Medicine and Rehabilitation in Hemiplegia. Maryland M.J. April* 1955.

Angina pectoris prevention



Most efficient of the new long-acting nitrates, METAMINE prevents angina attacks or greatly reduces their number and severity. Tolerance and methemoglobinemia have not been observed with METAMINE, nor have the common nitrate side effects such as headache or gastric irritation. Dose: 1 or 2 tablets after each meal and at bedtime. Also: METAMINE (2 mg.) with BUTABARBITAL (¼ gr.), bottles of 50. THOS. LEEMING & CO., INC., 155 EAST 44TH STREET, NEW YORK 17, N.Y.

unique amino nitrate

Metamine®

triethanolamine trinitrate biphosphate, Leeming, tablets 2 mg. Bottles of 50 and 500

"I can still do a big wash every week and never mind it at all!"



Many a modern grandmother is a fair match for the younger members of her family. To help such persons sustain their activities as they grow older, dietary supplementation may be desirable. GEVRAL provides 14 vitamins, 11 minerals and purified intrinsic factor concentrate in one convenient capsule for geriatric use.

Gevral*

Geriatric Vitamin-Mineral Supplement Lederle

Each GEVRAL capsule contains:

Vitamin A	5000 U.S.P. Units	Choline Dihydrogen Citrate	100 mg.	Calcium (as $CaHPO_4$)	145 mg.
Vitamin D	500 U.S.P. Units	Inositol	50 mg.	Phosphorus (as $CaHPO_4$)	110 mg.
Vitamin B_{12}	1 mcgm.	Ascorbic Acid (C)	50 mg.	Boron (as $Na_2B_4O_7.10H_2O$)	0.1 mg.
Thiamine Mononitrate (B_1)	5 mg.	Vitamin E (as tocopheryl acetates)	10 I. U.	Copper (as CuO)	1 mg.
Riboflavin (B_2)	5 mg.	Rutin	25 mg.	Fluorine (as CaF_2)	0.1 mg.
Niacinamide	15 mg.	Purified Intrinsic Factor Concentrate	0.5 mg.	Manganese (as MnO_2)	1 mg.
Folic Acid	1 mg.	Iron (as $FeSO_4$)	10 mg.	Magnesium (as MgO)	1 mg.
Pyridoxine HCl (B_6)	0.5 mg.	Iodine (as KI)	0.5 mg.	Potassium (as K_2SO_4)	5 mg.
Ca Pantothenate	5 mg.			Zinc (as ZnO)	0.5 mg.

Other Lederle geriatric products include: GEVRABON* Vitamin-Mineral Supplement Liquid with a wine flavor; GEVRAL* Protein Vitamin-Mineral-Protein Supplement Powder; and GEVRINE* Vitamin-Mineral-Hormone Capsule.

Lederle LEDERLE LABORATORIES DIVISION *AMERICAN Cyanamid COMPANY* Pearl River, New York

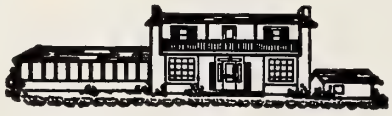
*REG. U.S. PAT. OFF.

North Shore Health Resort

on the shores of Lake Michigan
WINNETKA, ILLINOIS
NERVOUS and MENTAL DISORDERS
ALCOHOLISM and DRUG ADDICTION
Modern Methods of Treatment
MODERATE RATES

Established 1901
Licensed by State of Illinois
Fully Approved by the American College of Surgeons
SAMUEL LIEBMAN, M.S., M.D.
Medical Director
225 Sheridan Road Winnetka 6-0211

DOCTOR! you will approve the 3C's
Comfort, Cleanliness, Convenience



at Bee Dozier's 3 Sanitariums for
Aged, Chronic, Senile, Convalescent Patients.

Hickory Hill,
Maple Hill, *Palatine*

Charming, healthful rural locations conveniently situated, 24 hour care by trained nurses and orderlies, tempting food and supervised diets all contribute to your patient's well-being or recovery. 18 years of experience.

ONE rate covers EVERYTHING. There are NO extras.

Bee Dozier invites your inspection. Write Box 288, Lake Zurich, Ill., or Phone 4661

How to do it

Last fall a young mother came to the offices of a county medical society near San Francisco and objected strenuously to the bill she had received from her obstetrician.

"He's charging us $700 for a cesarean operation," she said. "I thought the standard price around here is only $250."

"Yes, the usual fee is around $250," said an association official. "But are you sure the doctor didn't mention a higher fee to you beforehand?"

The woman shook her head. "He didn't mention any fee before the operation," she said. "And now he won't even discuss the bill with me."

"All right. We'll look into it."

Three weeks later, after an exhaustive investigation, the chairman of one of the association's special committees visited the obstetrician.

"Your patient can probably afford to pay you $700," he said, "but that doesn't seem to be the point. You didn't tell her ahead of time that you were going to charge her more than

FAIRVIEW
Sanitarium

DEVOTED TO THE ACTIVE TREATMENT OF
MENTAL and NERVOUS DISORDERS

Specializing in Psycho-Therapy, and Physiological therapies including:
- **Electro-Shock**
- **Electro-Narcosis**
- **Insulin Shock**
- **Carbon Dioxide Therapy**

Out Patient Shock Therapy Available
ALCOHOLISM Treated by Comprehensive Medical-Psychiatric Methods.

2828 S. PRAIRIE AVENUE, CHICAGO 16 J. DENNIS FREUND, M. D., Medical Director
Phone Victory 2-1650 **Registered by the American Medical Assn.**

The NORBURY SANATORIUM

JACKSONVILLE, ILLINOIS — INCORPORATED and LICENSED

For the Treatment of Nervous and Mental Disorders

FRANK GARM NORBURY, M.D., Medical Director
HENRY A. DOLLEAR, M.D., Superintendent
FRANK B. NORBURY, M.D., Associate Physician

Address Communications — THE NORBURY SANATORIUM, Jacksonville, Illinois

the usual fee. There's nothing on the record to show she had any complication. You didn't give her any special services."

"So what?"

"Well, can you bring your price down to the usual fee? We've all agreed that this plan is best for the public, and. . ."

"I don't believe in that nonsense!" snapped the obstetrician. "Nobody is going to tell me how to charge my patients. She pays me that $700 in full or I take it to court. And how do you like that?"

"Of course, it's up to you," said the chairman. "But the members of my committee have instructed me to tell you this: if you go to court, we'll see to it that your patient is defended by the attorney for the county medical association. And, if necessary, we'll put every doctor on the committee on the stand to testify that your fee is extortionate."

"I guess I made a mistake", the obstetrician said. "The bill is the usual $250." *Milton Silverman. The Doctors Who Crack Down on Doctors. The Saturday Evening Post Copyright,* 1955 *by the Curtis Publishing Co.*



in whooping cough

ELIXIR BROMAURATE

IS A UNIQUE REMEDY OF UNIQUE MERIT

Cuts short the period of illness and relieves the distressing spasmodic cough. Also valuable in Bronchitis and Bronchial Asthma.

In four-ounce original bottles. A teaspoonful every 3 to 4 hours.

Prescribed by Thousands of Doctors

GOLD PHARMACAL CO. — NEW YORK CITY

Mercy Hospital Institute of Radiation Therapy

The Henry Schmitz Medical Group

For Appointment
Victory 2-4700, Ext. 170 or RAndolph 6-4444

Herbert E. Schmitz, M.D., *Director*
Peter A. Nelson, M.D., *General Oncology*
Henry L. Schmitz, M.D., *Internal Medicine*
Janet Towne, M.D., *Gynecology*
Robert L. Schmitz, M.D., *General Surgery*
John F. Sheehan, M.D., *Pathologist*
Charles J. Smith, M.D., *Gynecology*
Charles S. Gilbert, M.D., *Internal Medicine*
William F. Cernock, M.D., *Internal Medicine*
Fred W. Eims, *Physicist*
Miss Hilda Waterson, R.N.
Helen Hansen, *Social Service*

COMPLETE TUMOR THERAPY
Including
SUPERFICIAL X-RAY THERAPY
DEEP X-RAY THERAPY up to 1,000 K.V.
RADIUM THERAPY

Daily Consultation at Institute
Tumor Clinic—Mercy Free Dispensary—Tuesday at 9 a. m.
Tumor Conference — J. B. Murphy Auditorium — Friday at 1 p. m.

Massive breasts

Certain misconceptions relative to mammaplasty are prevalent and an attempt will be made to correct them. It is true that a breast with a free nipple transplant will not lactate but these massive breasts are relatively functionless. It is claimed that scarring is extensive and conspicuous and the operation is multilating. If the operation is done properly, most of the scars are hidden in the inframammary fold. The operation is not mutilating and a well-shaped breast can be reconstructed. As to the effects of pregnancy after a plastic procedure, no changes have been noted. The breasts increase but little in this state and promptly return to normal after delivery. As to the possibility of the loss of a nipple, this is relatively rare for, with care in the handling of this structure, the chances for a 100 per cent take are good. The transplanted nipple, in many cases, regains sensation and erectibility. *Daniel Klein, M.D. Mammaplasty for Hypertrophy of the Breasts. New York J. M. June* 1, 1955.

Lederle

FOLBESYN*

Vitamins *Lederle*

A well-balanced, high-potency vitamin formula containing B-Complex and C

FOLBESYN provides B-Complex factors (including folic acid and B_{12}) and ascorbic acid in a well balanced formula. It does not contain excessive amounts of any one factor.

FOLBESYN Parenteral may be administered intramuscularly, or it may be added to various hospital intravenous solutions. It is useful for preoperative and postoperative treatment and during convalescence.

Dosage: 2 cc. daily. Each 2 cc. provides:

Thiamine HCl (B_1)	10 mg.
Sodium Pantothenate	10 mg.
Niacinamide	50 mg.
Riboflavin (B_2)	10 mg.
Pyridoxine HCl (B_6)	5 mg.
Ascorbic Acid (C)	300 mg.
Vitamin B_{12}	15 micrograms
Folic Acid	3 mg.

FOLBESYN is also available in tablet form, ideal for supplementing the parenteral dose.

LEDERLE LABORATORIES DIVISION *AMERICAN Cyanamid COMPANY* Pearl River, New York

*REG. U.S. PAT. OFF.

Markedly less toxic
than either
potassium iodide
or Lugol's Solution,

AMEND'S SOLUTION is
iodine in its most effective and
safest form.

Whenever oral iodine
is indicated, prescribe
10 to 20 drops of
AMEND'S SOLUTION
t.i.d., a.c., in a full glass
of water. Available in
2 oz. bottles.

AMEND'S SOLUTION
(*protein-buffered iodine*)

Additional information available on request.

Thos. Leeming & Co. Inc.
155 East 44th Street, New York 17, N.Y.

BELLEVUE PLACE

For
NERVOUS and MENTAL DISEASES

★

Edward Ross, M.D., Medical Director
BATAVIA ILLINOIS
PHONE BATAVIA 1520

THUMBSUCKING

since infancy caused this malocclusion.



THUM TRADE MARK

THUM broke the habit and teeth returned to normal position.

ACCEPTED FOR ADVERTISING IN PUBLICATIONS OF THE AMERICAN MEDICAL ASSOCIATION

Get Thum at your druggist or surgical dealer.
Prescribed by physicians for over 20 years.

Classified Ads

RATES FOR CLASSIFIED ADVERTISEMENTS—For 30 words or less: 1 insertion, $3.00; 3 insertions, $8.00; 6 insertions, $14.00; 12 insertions, $24.00; from 30 to 50 words: 1 insertion, $4.00; 3 insertions, $10.50; 6 insertions, $20.00; 12 insertions, $30.00. Extra words: 1 insertion 10c each; 3 insertions, 25c each; 6 insertions, 40c each; 12 insertions, 50c each. A fee of 25c is charged for those advertisers who have answers sent care of the Journal. Cash in advance must accompany copy.

WANTED: Physician, 40-55, as staff member of active private sanitarium for diseases of addiction. Permanent, full-time, salaried position for qualified physician preferably with a background of general practice. Please apply by letter to James I. Oughton, administrator, The Keeley Institute, Dwight, Ill. 7/55

FOR SALE: Spencer microtone complete with freezing attachment. Price $175.00. Call Central 6-1565 or Mansfield 6-2388. 9/55

WANTED: Physician for July and August, Ill. license. Reasonable income, plus percentage. Partnership considered. Write to Dr. Max Schlosser, 510 Standard Office Bldg., Decatur, Ill., or call 6642 collect.

Building in Oak Park, Illinois containing 4500 sq. ft. can be made suitable as a medical center. Owner will remodel. Call Mr. Oviatt, FRanklin 2-7070.

The battle of life

In resisting the useless expenditure of energy, man's fight with time is his greatest battle. In that battle his emotional life is highly important, the surplus of hope over despair, of love over indifference, of motive over resignation. As Helton points out, it is not a fight for the duration of the body so much as it is a fight for the duration of the capacity for happiness. One can be too busy and too active in the process of maturing to be annoyed by the deteriorations of aging. Purposeful activity up to the limits of physiologic and mental optimum represents the most potent factor in the fight against premature human deterioration. *Edward L. Bortz, M.D. Stress and Aging. Geriatrics. March* 1955.

Do You Know ? ? ?

THE SPECIAL DISABILITY PLAN
AVAILABLE TO MEMBERS OF
THE ILLINOIS STATE MEDICAL SOCIETY

Provides Benefits up to . .

$5000. ACCIDENTAL DEATH AND DISMEMBERMENT
$100. PER WEEK FOR TOTAL LOSS OF TIME as the result of either Sickness or Accident.
$15. DAILY HOSPITALIZATION for up to 90 days as the result of either Sickness or Accident.

Plus . . .

Optional 5 Year Sickness Coverage
No reduction in benefits because of other insurance
Full benefits to age 70 at same cost
(All Benefits Subject to Provisions of the Policy)

FOR ALL THE FACTS - - -
Write or Telephone
PARKER, ALESHIRE & COMPANY
175 W. JACKSON BOULEVARD
Chicago 4, Ill. WAbash 2-1011

"I do not think that 70 years is the time of a man or woman,
Nor that years will ever stop the existence of me or any one else."

—*Walt Whitman*

THE KEELEY INSTITUTE
DWIGHT, ILLINOIS

Treating alcoholism and other problems of addiction.
REGISTERED BY THE AMERICAN MEDICAL ASSOCIATION—
MEMBER AMERICAN HOSPITAL ASSOCIATION.

Table of Contents

AUGUST, 1955
Vol. 108, No. 2

Editor
Harold M. Camp
Monmouth, Illinois

Associate Editor
Theodore Van Dellen
Chicago, Illinois

Business Manager and Managing Editor
Mr. L. E. Malley
185 N. Wabash Avenue
Chicago 1, Illinois

Business Office
185 N. Wabash Avenue
Chicago 1, Illinois

Editorial Office
Medical Arts Building
Monmouth, Illinois

Send original articles and membership correspondence to Harold M. Camp, Monmouth, Ill.

Send changes in the mailing list to Managing Editor, 185 N. Wabash Ave., Chicago 1, Ill.

Subscription price of this JOURNAL to persons not members of the Illinois State Medical Society is $4.00 per year, in advance, postage prepaid, for the United States, Cuba, Puerto Rico, Philippine Islands, Hawaiian Islands and Mexico. $5.00 per year for all foreign countries included in the postal union. Canada, $4.50. Single current copies 50 cents. By mail, 60 cents.

HOUSE OF DELEGATES

Second Session 141
Third Session 150

ORIGINAL ARTICLES

X-Ray Diagnosis in Pediatrics, Frederic N. Silverman, M.D., Cincinnati, Ohio 95
Modern Management of Pulmonary Tuberculosis, M. R. Lichtenstein, M.D., Chicago 101
Medicine and Citizenship, Ernest E. Irons, M.D., Chicago 107
The Guthrie Stone I. Frederick Stenn, M.D., Chicago 112
Samuel Guthrie II. (1782-1848) Physician, Inventor, Chemist, Farmer, Frederick Stenn, M.D., Chicago 113
Power Lawn Mower Decortication of Scalp and Skull, (Case Report) M. E. Kurth, M.D., R. J. Drever, M.D., Chicago, and Charles Baran, M.D., South Bend, Indiana 117
Cat Scratch Disease, (Case Report) Irving Rudman, M.D., and John R. Cummings, M.D., Frankfort 120

EDITORIALS

The wonder drugs 121
The polio lesson 121
Section officers for 1956 annual meeting 122
Pictorial report on the 1955 annual meeting 123
Book Reviews 42A

MEDICAL ECONOMICS

Purposeful Living, Edwin F. Hirsch, M.D., Chicago 128

CORRESPONDENCE

Psychiatric lecture series for all physicians 133
Postgraduate Assembly of the Endocrine Society 133
He was there 133
Clinics for crippled children listed for September 134
The American Congress of Physical Medicine and Rehabilitation .. 134
New appointments at Northwestern University Medical School 135
Instruction in occupational skin problems 135
Officers of Illinois Medical Service Blue-Shield Plan 135
Course in postgraduate gastroenterology 135
Mississippi Valley Medical Society meeting 136
Post graduate courses on diseases of the chest 136
Hektoen institute awards 136

NEWS OF THE STATE 137

Entered as Second-Class Matter November 12, 1952 at the Post Office, Mendota, Illinois, under the Act of March 8, 1879. Acceptance for mailing at special rate postage provided for in section 1102, Act of October 8, 1917, authorized July 15, 1918. Printed monthly by The Wayside Press, Mendota, Illinois. Office of Publication, 1501 W. Washington Road, Mendota, Illinois. POSTMASTER — Return undeliverable copies under form 3579 to 1501 W. Washington Road, Mendota, Illinois.



Smith, Kline & French Laboratories, Philadelphia

formulas Available in *two* dosage strengths: 'Dexamyl' *Spansule* (No. 1), containi Dexedrine* Sulfate (dextro-amphetamine sulfate, S.K.F.), 10 mg., and amobarbit 1 gr.; 'Dexamyl' *Spansule* (No. 2), containing 'Dexedrine' Sulfate, 15 mg., a amobarbital, 1½ gr. Also available: 'Dexamyl' Tablets and Elixir.

establishing

desired

eating patterns



Obedrin®

and the 60-10-70 Basic Diet

Correct medication is important in initiating control that leads to development of good eating habits, essential in maintaining normal weight.[1,2,3]

Obedrin contains:

- Methamphetamine for its anorexigenic and mood-lifting effects.
- Pentobarbital as a corrective for any excitation that might occur.
- Vitamins B_1 and B_2 plus niacin for diet supplementation.
- Ascorbic acid to aid in the mobilization of tissue fluids.

Obedrin contains no artificial bulk, so the hazards of impaction are avoided. The 60-10-70 Basic Diet provides for a balanced food intake, with sufficient protein and roughage.

Formula:

Semoxydrine HCl (Methamphetamine HCl) 5 mg.; Pentobarbital 20 mg.; Ascorbic acid 100 mg.; Thiamine HCl 0.5 mg.; Riboflavin 1 mg.; Niacin 5 mg.

1. Eisfelder, H. W.: Am. Pract. & Dig. Treat., 5:778 (Oct.) 1954.
2. Sebrell, W. H., Jr.: J.A.M.A., 152:42 (May) 1953.
3. Sherman, R. J., M.D.: Medical Times, 82:107 (Feb.) 1954.

Write for 60-10-70 Diet pads, Weight Charts, and samples of Obedrin.

THE S. E. MASSENGILL COMPANY
Bristol, Tennessee

METICORTEN
PREDNISONE (metacortandracin)
more potent than cortisone or hydrocortisone • devoid of major undesirable side effects
Schering
METICORTEN,* brand of prednisone.
*T.M.

Thymoma

In 1951, Fershtand and Shaw reported the history of a patient with a large thymoma in whom severe myasthenic symptoms developed immediately after removal of the tumor. At that time these authors reported they had not been able to discover a similar reported case. Recently a patient was admitted to the New England Center Hospital whose first signs and symptoms of myasthenia gravis also immediately followed removal of a large thymoma that had metastasized, by implantation, to the right lung, pleural cavity, and diaphragm. Because this train of circumstances appears to be rare it is believed that this case merits a report. *John H. Fisher, M.D. and Charles G. Child, III, M.D. Myasthenia Gravis Developing Acutely After Partial Removal of a Thymoma. New England J. Med. May* 26, 1955.

‹ ›

More consultations

A large majority of our malpractice claims could be prevented if all of us would have consultation much more often than we do. None of us knows eveything and help is definitely needed. The doctors who have been in practice a number of years can feel or sense when the patient or family begins to be dissatisfied. This is the moment to ask one of your colleagues to see the patient with you before the patient or his family demands it. For the younger man it is not an admission of weakness or lack of knowledge that he asks for consultation. Our hospitals encourage and want you to have consultation. *C. C. Craig, M.D. Are you Afraid to have Consultation? Arizona Med. May* 1955.

‹ ›

What is to happen to the derelicts? Although tuberculosis occurs in any type, level or stratum, there are people especially prone—the dispossessed and the defeated, the disintegrated and the defenseless. The teacher who cannot get a job because of some X-ray shadow; the young man excluded from industry; the man who finds he cannot enter any superannuation scheme because of a past history of tuberculosis—what are we to do with them? Harley Williams, M.D., Nat. Tuberc. A. Tr., May, 1954.

The
ILLINOIS
Medical Journal

Official Journal of The Illinois State Medical Society

AUGUST 1955
VOL. 108 NO. 2

X-Ray Diagnosis in Pediatrics

FREDERIC N. SILVERMAN, M.D., CINCINNATI, OHIO

A SHORT time ago, an opportunity was provided to review an unpublished paper by Dr. Robert Lenk,* a former Viennese Roentgenologist, in which he discussed the differences between x-ray diagnosis in adults and x-ray diagnosis in children. Dr. Lenk's ideas coincide so closely to my own that it would be unfair to present the following material without acknowledging the support given it by the knowledge that a man of Dr. Lenk's great experience agrees with it in principle, if not in fact.

What is the difference between x-ray diagnosis in pediatrics and x-ray diagnosis in general? An obvious answer would be the age and size of the patients examined; but that is not enough. If we carefully consider the question, it is seen that the same factors which differentiate pediatrics from general adult medical practice demand a special study of the radiologic manifestations of health and disease in children. These are factors related to the biologic peculiarities of the growing organism as opposed to those of the fully formed individual. Of these factors, four can be selected for special emphasis. These are: (1) congenital malformations, (2) growth and development, (3) diseases with seeds sown in infancy and childhood and (4) diseases peculiar to infants and children.

CONGENITAL MALFORMATIONS

Many congenital malformations are incompatible with longevity. The physician concerned only with adults may be totally unfamiliar with the manifestations of such malformations. Yet, advances in surgery have now made it possible for many of these conditions to be corrected or even cured, if recognition can be made in proper time. An example is provided by the following case report:

J. L., a 3 year old white boy was said to be well until 2 months before admission to the hospital when he first complained of discomfort during voiding. He had never achieved bladder control, according to his mother, and was constantly wet. No statement was elicited concerning the nature of the urinary stream during the act of voiding. Following the first complaint of strangury, the child was noted to have episodes in which he would suddenly sit on the floor and become "tense" for a few minutes. Sometimes he would wet himself during these episodes, and at other times no relationship to voiding was noted. The possibility of epilepsy was considered but because there was a history of strangury, his physician requested roentgen examination of the urinary tract, expecting to exclude organic disease prior to investigation of the central nervous system.

The upper urinary tract was normal (Figure

From the Departments of Pediatrics and Radiology of the College of Medicine, University of Cincinnati, Children's Hospital and the Children's Hospital Research Foundation

* Biology As The Basis of Pediatric X-Ray Pathology. Jl. Fac. Radiol. 6:51-61, July, 1954.

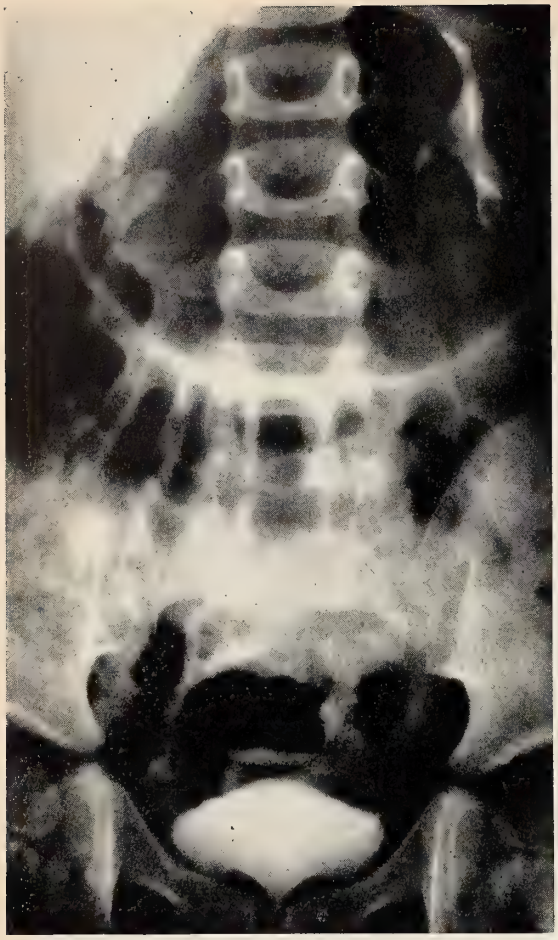


Figure 1: Excretory urogram showing normal upper urinary tract, but abnormal bladder neck without evidence of obstruction. Child enuretic; recent strangury.

1); both renal pelves were visualized, as were the ureters and no malformations or evidence of obstructive uropathy was found. The bladder was not dilated, but its walls were faintly irregular as if trabeculation were marked. In addition, the outflow area was abnormal suggesting relaxation of the internal sphincter. Because the concentration of contrast substance was considered adequate, a voiding urethragram was obtained. This simple procedure of exposing an x-ray film of the bladder and urethra during the act of voiding, demonstrated conclusively an obstruction in the urethra with dilatation proximal to it (Figure 2). The findings were characteristic of posterior urethral valves which were found on urethroscopy and removed surgically. This has been followed by complete cure of symptoms, including the enuresis. The bladder had been able, up to the time of diagnosis, to hypertrophy and compensate for the increased pressure required to force urine past the obstruction. The upper urinary tract therefore could empty adequately into the bladder.



Figure 2: Voiding urethragram. Same patient as in Figure 1. Dilated posterior urethra due to posterior urethral valves.

This situation contrasts with the case of another child who was seen some years ago shortly before his death of renal failure. He had been considered for years to have "neuro-



Figure 3: Cystogram showing bladder dilatation, pseudodiverticula, and marked hydronephrosis and hydroureter. Obstruction not identified. (Courtesy of Radiology).

genic uropathy" because he dribbled frequently and was unable to void in a sustained stream. When a cystogram was performed on this child (Figure 3) retrograde filling of the ureters occurred and demonstrated a radiologic picture entirely consistent with long standing inability to empty the bladder, including neurogenic uropathy. The ureters were elongated and tortuous and enlarged almost to the size of bowel. The bladder was dilated and demonstrated multiple trabeculations and pseudodiverticula. No evidence of obstruction was provided. However, when this child was placed in the lateral oblique projection and instructed to void, a film during



Figure 4: Voiding urethragram. Same patient as in Figure 3. Typical picture of posterior urethral valves. (Courtesy of Radiology).

the act of voiding (Figure 4) demonstrated the characteristic deformity of posterior urethral valves unfortunately too late to provide any surgical relief.

GROWTH AND DEVELOPMENT

The changing pattern of physical structure in the growing organism may produce morphologic and anatomic conditions which would indicate serious disease in the mature individual. Many diseases of the skeleton are characterized by areas of irregular mineralization. In childhood these are areas where irregular mineralization occurs as a result of normal developmental processes. In the adult, the irregular mineralization is a consequence of pathologic change in already formed bone which causes it to become fragmented, demineralized or sclerotic; in the child, the same radiographic features are produced by the appearance of ossification centers in previously invisible cartilage which has not yet changed completely to bone. Two common examples should suffice to illustrate the effect of growth and development of the skeleton on roentgen diagnosis.

The ossification center for the epiphysis of the femur at the knee generally makes its appearance between the 8th and 9th fetal months. The cartilaginous portion of the bone at this time includes the condyles and the intercondylar notch which are radiologically invisible. The ossification center actually makes its appearance somewhere near the center of this cartilaginous termination in the bone. With the passage of time, the ossification center enlarges extending out toward the margins of the epiphysis and ultimately all of the cartilage is changed into bone except the most distal portion which persists as articular cartilage. During the period when lateral growth of the epiphyseal ossification center is rapid, irregular extensions of osseous tissue dip into the surrounding cartilage. This gives, in the roentgenogram, a markedly irregular appearance on the medial and lateral aspects of the epiphyseal ossification center which suggests that a grating feeling might be felt if the knee were to be flexed (Figure 5). However, these are only irregular extensions into the cartilage and the remainder of the cartilage, still invisible, is smooth and regular and without disease.

A second example is provided by the film

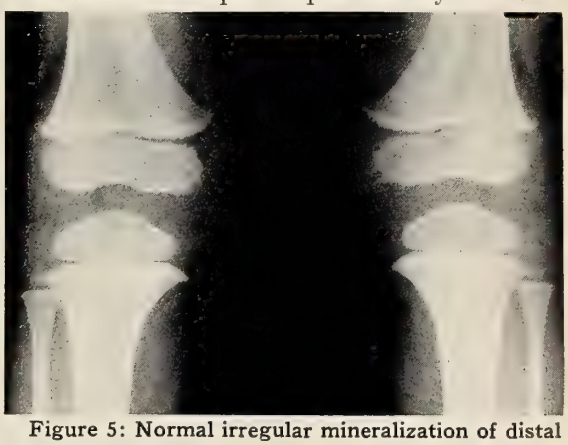


Figure 5: Normal irregular mineralization of distal femoral epiphyses. Note irregular margins of medial borders.

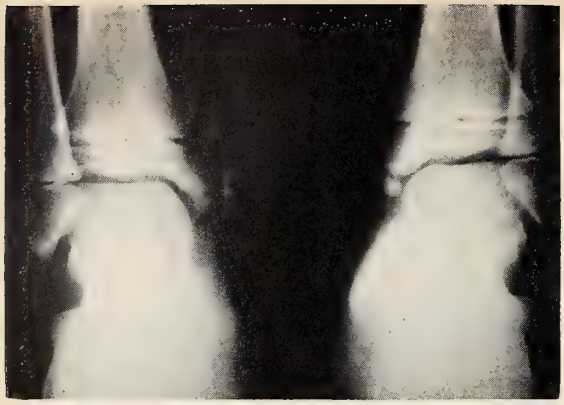


Figure 6: Injury to right ankle. Ununited ossification center in internal malleolus simulates fracture, but counterpart is seen in corresponding region of uninjured left ankle.

(Figure 6) of a child who twisted his ankle and was brought to the x-ray department for examination because of the suspicion of a fracture. In the film, the metal clips holding the elastic bandage tightly around the ankle are clearly seen and at the tip of the medial malleolus, there is a fragment of bone separated from the main portion of the epiphysis by a radiolucent line which at first glance is easily accepted as a fracture. However, when the opposite ankle is examined, a similar "fragment" of bone is found in the same area. If we think in terms of the cartilaginous epiphysis at the ends of the shaft of the long bones, we immediately realize that the "fragment" of bone merely represents an accessory ossification center which has not yet fused with the main ossification center; and the transverse radiolucent line which appears to be a fracture is cast by a zone of cartilage which has not yet changed to bone, and across which there is continuity of tissue rather than the discontinuity of fracture. In addition to calling attention to the frequent occurrence of irregular ossification centers in incompletely ossified cartilaginous bone of children, this film also points out a helpful procedure for evaluating these shadows. Generally, accessory ossification centers occur in a symmetrical pattern in the body; examination of a healthy part frequently prevents over-diagnosis when comparison is made with the corresponding part in which disease is suspected. The occasional asymmetry of these ossification centers points up the need for correlation of the radiologic findings with the clinical manifestations at all times.

DISEASES WITH SEEDS SOWN IN INFANCY AND CHILDHOOD

Post primary pulmonary tuberculosis in adults can be considered an excellent example of a condition of which the roots go back to childhood. However, for purposes of discussion today, our remarks shall be confined to a consideration of the adult who is a respiratory invalid as a consequence of recurrent respiratory infection and bronchiectasis. Not infrequently, in such cases, if one goes back into the history, there will be elicited a story of severe measles or pertussis in childhood, following which began a lengthy history of recurrent respiratory disease. In the course of measles, an interstitial pneumonia is frequently encountered. This represents an inflammatory reaction in the framework of the lung, which may lead to subsequent scarring and distortion unless the secondary infection which accompanies it is adequately controlled. Of particular importance is the occurrence of atelectasis or collapse of segments of the lung which may escape clinical detection. If such areas are permitted to remain, chronic inflammatory changes occur, there is interference with drainage and aeration, and the stage is set for subsequent development of chronic debilitating respiratory disease. If one were able to take only a single roentgen film of a patient with measles to gauge the therapy for this patient, a film taken at what appears to be the clinical completion of the disease would probably be most valuable (Figure 7). Roentgen examination of the chest during and after measles in childhood may anticipate and lead to prevention of respiratory disease later in life.

DISEASES PECULIAR TO INFANTS AND CHILDREN

Rickets, lead encephalopathy, infantile cortical hyperostoses and other conditions have diagnostic roentgen appearances in infancy and childhood and do not occur or are manifested in a different fashion in adults. A similar condition which has interested us greatly has been the radiologic manifestations of unrecognized skeletal trauma in infants and children. This is best exemplified by citing a typical case:

J. S., a 4½ month old infant was sent to the x-ray department with the diagnosis of bone tumor. The child was clinically well and the diagnosis was made by the referring pediatrician when, in the course of a routine physical exami-

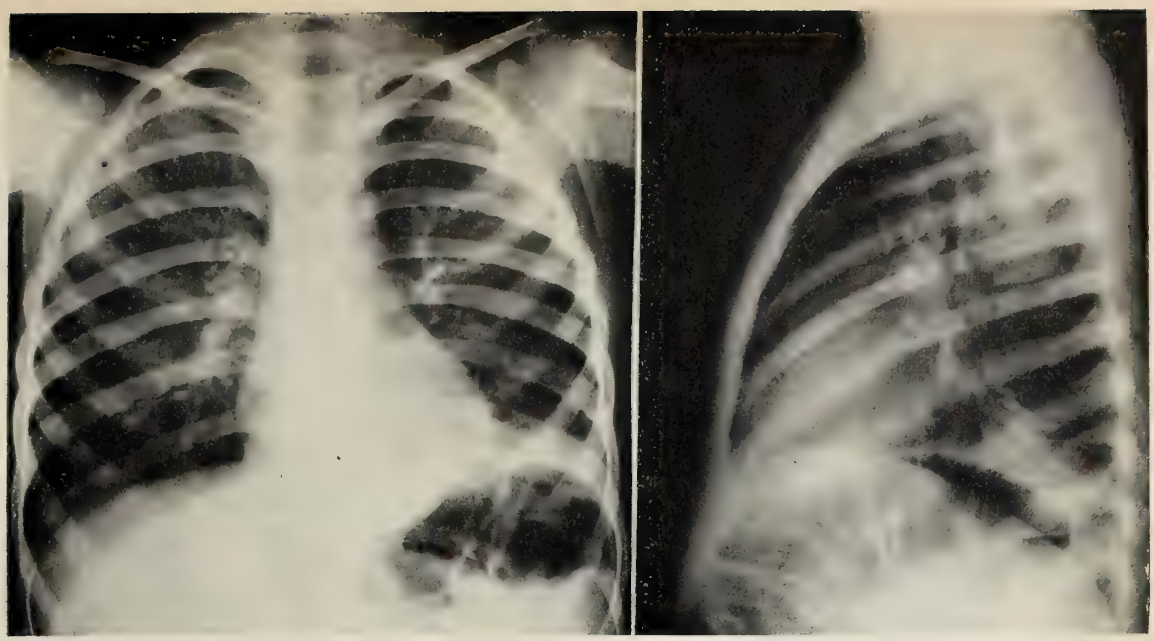


Figure 7: Persistent atelectasis after measles. Fever persisted for 6 weeks after acute illness was over. No clinical signs of lung disease. Expansion of lung and disappearance of fever after brochoscopic aspiration. A. Frontal projection. Note elevation of left leaf of diaphragm and indistinct margin. B. Lateral projection. Segmental collapse of lower lobe clearly defined.

nation, he palpated a hard bony mass at the proximal end of the right femur. X-ray examination (Figure 8) appeared to corroborate the diagnosis of bone tumor since a productive bony shell was seen around the proximal end of the right femur. However, examination of the remainder of the skeleton disclosed comparable changes in some of the other bones as well as what appeared to be destructive lesions in the ends of the shafts of some of the bones. Scurvy, rickets, syphilis, polyostotic osteomyelitis were all excluded by appropriate examinations. Careful questioning of the parents finally revealed that approximately four weeks earlier, a bathinette had collapsed while the baby was in it. In order to prevent the baby from falling to the floor, the father had practically caught him in mid air by the legs. This incident had been forgotten although for 1½ weeks after the accident, there was noted some disinclination of the child to use the right leg. Subsequent follow-up examination showed progressive healing of all the lesions, the only residual being coxa vara deformity at the right hip due to traumatic epiphyseal separation.

In some patients the radiologic manifestations have been even more bizarre and are believed related to repeated trauma (Figure 9). Careful hematologic studies have failed to indicate any bleeding tendencies, a feature suggested by some of the radiologic signs which closely simulate the subperiosteal hemorrhage of scurvy. It is believed that the productive bone changes external to the shafts result from hemorrhage under the periosteum which is loosely attached in infancy and childhood, and which, by relatively minor trauma, may be separated from the bone. The reason that these cases are not seen more often is partly explained by the fact that roentgen examination is generally undertaken, if trauma is recognized, shortly after the trauma occurs. The radiologic manifestations described above are the reparative changes which do not make their appearance ordinarily until two or three weeks after the injury. In this interval clinical recovery takes place and the indications for repeat roentgen examination therefore are lacking. In serial follow-up studies of children who have had known trauma and no radiologic lesions initially, we have been able to identify with considerable frequency the same type of reparative change at a time when, from clinical indications, no roentgen examination would have been considered necessary. The importance of recognizing this entity is primarily to differ-

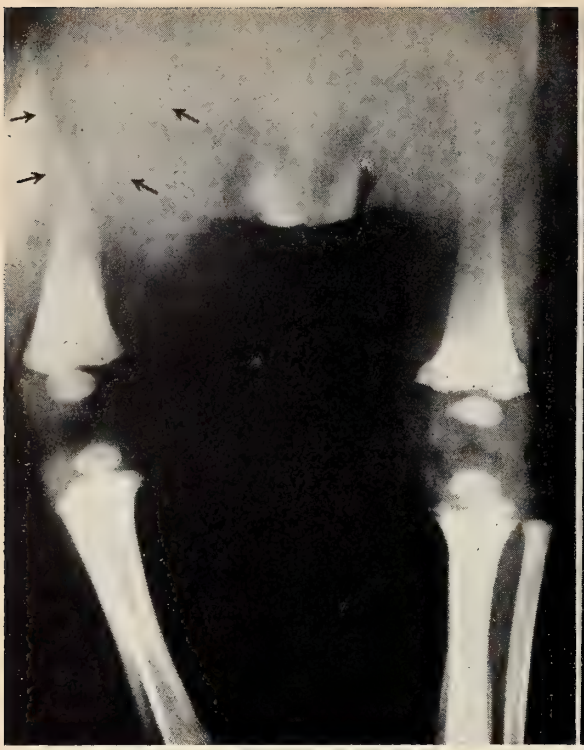


Figure 8: Unrecognized skeletal trauma. Clinical diagnosis of "bone tumor" right thigh. Other lesions clinically silent. Adequate history of trauma obtained subsequently. (Courtesy of Amer. J. Roentgenol.)

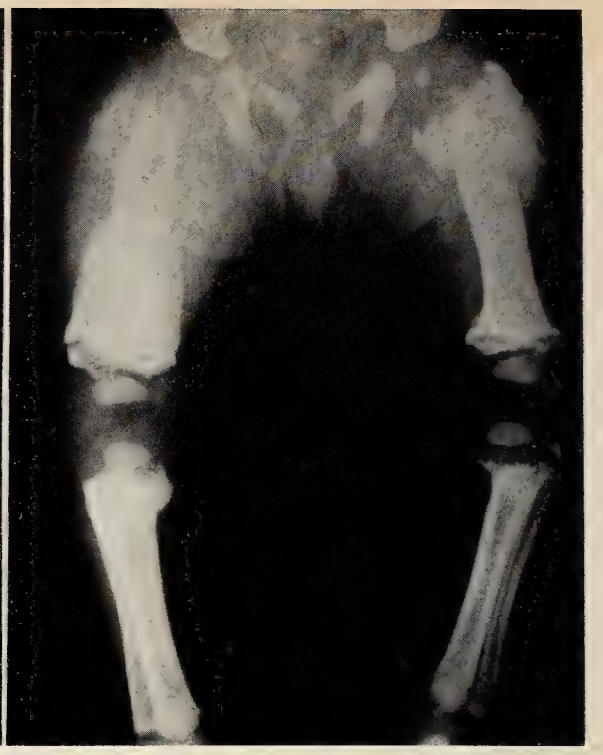


Figure 9: Unrecognized skeletal trauma. Unexpected roentgen findings in lower extremities after known injury to shoulder. History of trauma subsequently elicited. (Courtesy of Amer. J. Roentgenol.)

entiate it from the more serious conditions which it may simulate and which radiologists, unfamiliar with the response of young growing bones to minor injuries, would have no recourse but to consider diagnostic possibilities of dire prognostic import, charged with tremendous emotional impact for parents, and leading to expensive and unrewarding diagnostic procedures or even dangerous and possibly multilating, ill-advised attempts at heroic therapy.

These are but a few of the examples of conditions which occur in infancy and childhood, which owe their development to the biological peculiarities of the growing child and which justify continued roentgen investigation of both the normal and the abnormal roentgenographic features of pediatrics. Rather than indicating the need for a new speciality, the concepts and observations described here support the continued collaboration of the broad fields of specialization already defined to the end that better medical care of the child of today can result in better health for the adult of the future.

Modern Management of Pulmonary Tuberculosis

M. R. Lichtenstein, M.D., Chicago

THIS article is intended as a guide for those physicians who are not familiar with the great changes which have occurred in tuberculosis management during the past few years. What drug regimens are available? Is it wise to change drugs at intervals? Can the patient be treated at home now? When is surgery indicated? These are common questions. This outline represents present day practice at the City of Chicago Municipal Tuberculosis Sanitarium and is founded upon principles which are accepted by leading authorities.

In general, modern management consists of chemotherapy and general supportive therapy for all patients with active pulmonary tuberculosis; pneumotherapy (for about 50% at M.T.S.) and definitive surgery (for about 20% at M.T.S.).

GENERAL SUPPORTIVE MEASURES

Sanitarium Care: General supportive therapy is aimed at improving the patient's resistance by means of appropriate rest, diet, and fresh air. The state of a patient's resistance (immunity) is the critical factor in his battle with tuberculosis. Treatment during the active stages of pulmonary tuberculosis is best carried out in a sanitarium. There, the patient is cut off from his business and family worries, is constrained to accept the necessary physical inactivity, to eliminate alcohol from his diet, and to follow hygienic routines. Attempts to reproduce the sanitarium regime in the patient's home almost always result in halfway measures.

Rest: The large majority of sanitariums, including M.T.S., use the plan called "Modified Bedrest" approximately as follows: If the patient is toxic or febrile, he is kept on complete bedrest. When severe symptoms have diminished, the patient is allowed bathroom privileges. After two or three months of treatment, if he is responding well, he is allowed out of bed three or four hours daily; however, he is required to spend two hours in bed in the morning and two hours in the afternoon. After four to six months of treatment, if marked x-ray improvement is occurring, the patient is allowed out of bed five hours daily and may go to classes for pre-vocational rehabilitation. Exercise is gradually increased until the patient can be classified as "inactive." At this point, he is ready to return to his job providing the work is not strenuous.

Diet: The patient should receive a well balanced, high caloric, high protein, high vitamin diet. No vitamin supplements are needed if the patient is able to eat his food reasonably well. Iron therapy is of no value in the anemia of tuberculosis but may be useful if the patient has had blood loss.

Fresh Air: The patients' rooms should be well ventilated but need not be kept uncomfortably cold.

CHEMOTHERAPY

Streptomycin, sodium para-aminosalicylate, isoniazid, and viomycin are the bacteriostatic drugs which are valuable in the treatment of tuberculosis. Because tubercle bacilli develop resistance to the drugs under certain circumstances, there are three important principles which must be followed to obtain optimum results. These principles are: (1) Give at least two of the drugs simultaneously. (2) The drugs should be given continuously and should not be interrupted throughout the entire period of treatment. (3) Therapy should be prolonged for many months, or even years, so that it will not have to be reinstituted later. The regimen most commonly used today consists of streptomycin, 1 gram twice weekly by intramuscular injection, and sodium PAS, 5 grams t.i.d. by mouth daily. Other regimens combining two or three of the above drugs are being studied but have not been proved to have any definite superiority. Isoniazid is generally used in doses of 100 mgm. to 200 mgm. by mouth t.i.d. It should be included in

Medical Director, City of Chicago Municipal Tuberculosis Sanitarium

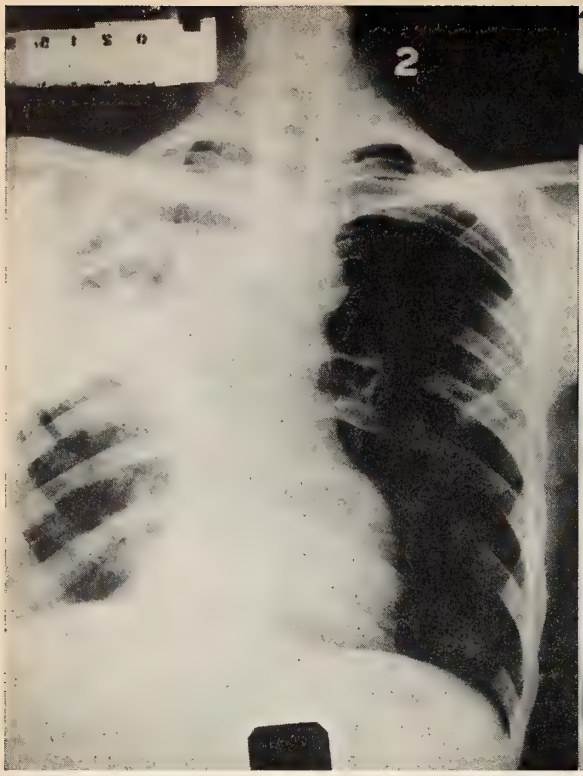


Figure 1a. Patient admitted to M.T.S. with bilateral tuberculosis and positive sputum.

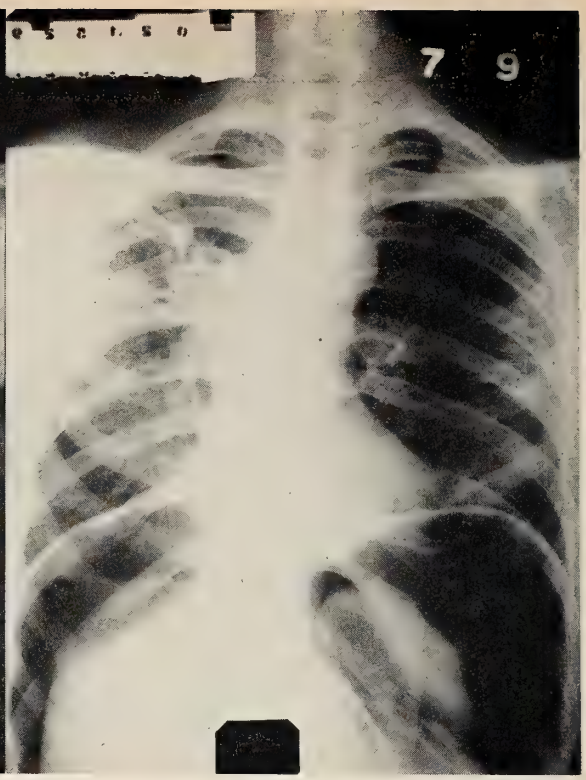


Figure 1b. After 5 months of chemotherapy (3 drugs) and 4 months of pneumoperitoneum, marked x-ray improvement has occurred and sputum concentrations are negative.

the regimen of those patients who develop meningitis or miliary tuberculosis. Viomycin, because of its toxicity, is usually withheld for use in those patients who have become resistant to the other drugs and require therapy to cover a special period, such as surgery. It can be given with relative safety in doses of 1 or 2 grams I.M. twice weekly.

Toxicity and Hypersensitivity: Toxic effects from streptomycin, PAS, or INH in the dosages mentioned are rare. PAS frequently causes mild abdominal discomfort and diarrhea during the early weeks of treatment. It should not be discontinued unless symptoms are severe. Calcium-PAS is frequently tolerated better.

The most frequent difficulty arises from hypersensitivity to PAS.[1] The patient develops sudden high fever, a rash, lymphadenopathy, and, in severe cases, may have enlargement of the liver with jaundice. Atypical lymphocytes resembling those seen in infectious mononucleosis may be noted in the severe cases.[2] Streptomycin hypersensitivity may result in fever and rash and may go on to exfoliative dermatitis. If either of these reactions occur, it is best to stop treatment with both drugs at once. After a four to six weeks' interval, treatment can be resumed with one drug at a time, beginning with very small fractional doses and increasing gradually. Streptomycin may be restarted with 10 mgm. doses and PAS with drop doses of a 20% solution.

Peripheral neuritis may occur in patients taking isoniazid, particularly alcoholics and diabetics. Recent reports claim that pyridoxine, 200 to 400 mgm. daily, is useful as a prophylactic measure.

Duration of Chemotherapy: Chemotherapy should be continued without interruption, if possible, until three to six months after the patient has been declared "inactive" and has returned to work. To be considered "inactive", the patient must meet the following requirements: (1) No symptoms. (2) X-rays must have shown maximal clearing, with stability for at least six months ,and with no evidence of cavitation. (3) Sputum or gastric wash cultures must be negative on three consecutive specimen. (See "Diag-

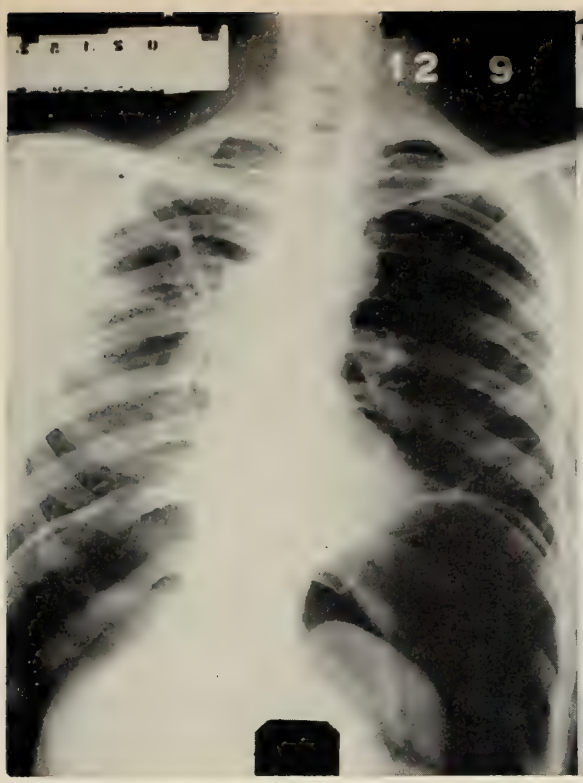


Figure 1c. After 10 months of treatment, maximal clearing and stability are established. Patient discharged to continue chemotherapy and pneumoperitoneum at out-patient clinic.

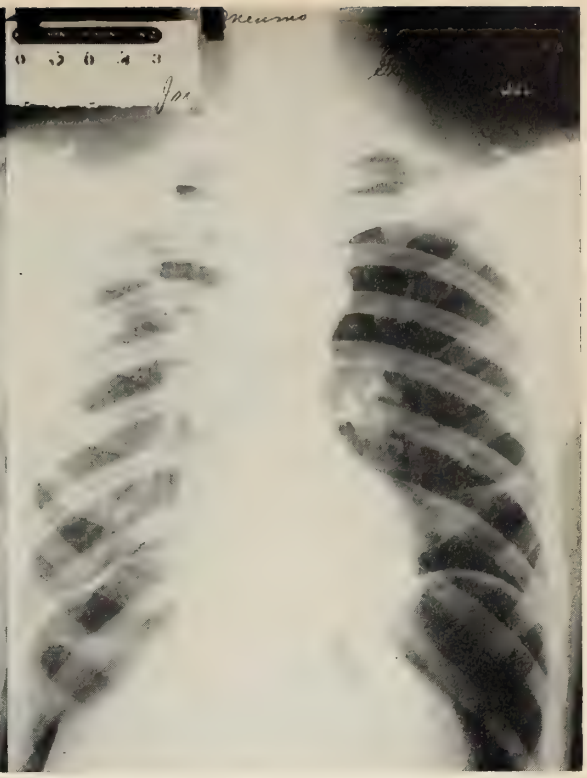


Figure 1d. 7 months later, patient has negative gastric cultures, is classified as inactive, and returns to work. Chemotherapy will be continued for about 6 months.

nostic Standards," 1950, National Tuberculosis Association.) If the patient continues to show active disease and cannot qualify for the "inactive" classification, chemotherapy is continued indefinitely. Twelve months of chemotherapy is considered the shortest period for all but minimal lesions. Most patients are treated for eighteen to twenty-four months.

PNEUMOTHERAPY

Pneumothorax has been practically discarded in the past few years because of the complications, which include air embolism, adhesions, empyema, and failure to re-expand.

Pneumoperitoneum is widely used because of its much greater safety than pneumothorax. It has the advantage of bilateral effectiveness. Although its value has been doubted in some sections of the country, recent carefully controlled studies have established the fact that it is definitely valuable in the closure of small cavities and helps prepare for surgery those with large cavities.[3,4] Pneumoperitoneum should be induced about one month after drug therapy is started. It is usually continued for periods ranging from one year to three years.

SURGERY

Surgery is necessary to complete the cure of these patients who have persisting cavities after about six months of chemotherapy. Cavities which have not closed after this period of treatment almost always remain open and will cause spread of the disease in the majority of patients because of the development of resistant tubercle bacilli within the open cavities. It is, therefore, highly important that surgery be completed at the earliest possible moment so that the patient will have the benefit of coverage by drugs which are still effective. The earliest safe period in which to perform the surgery is usually held to be the time at which stability is demonstrated on serial x-rays. This means that little or no change has occurred over a period of two or three months on successive films. Operation during the earlier stages of active disease while the lesion is acute or changing is frowned upon because there is an additional hazard of spread at such times. It is not within the scope of this

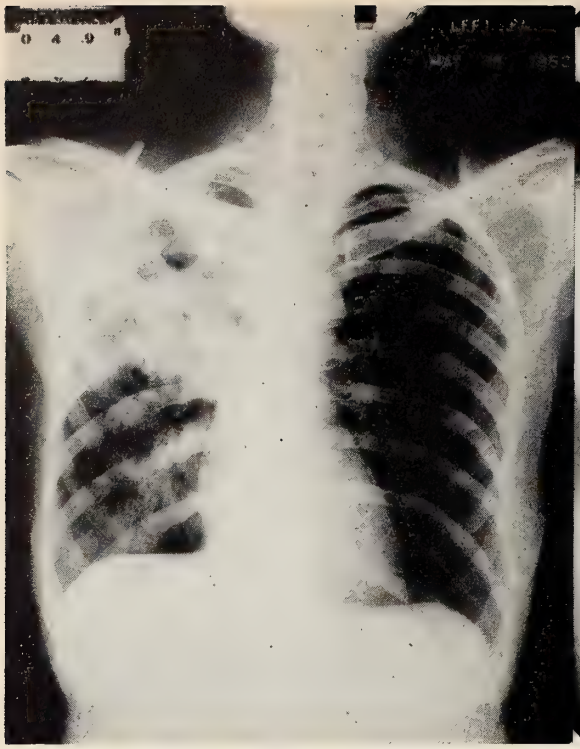


Figure 2a. Extensive pulmonary tuberculosis with large cavity in right upper lobe, May 16, 1952.

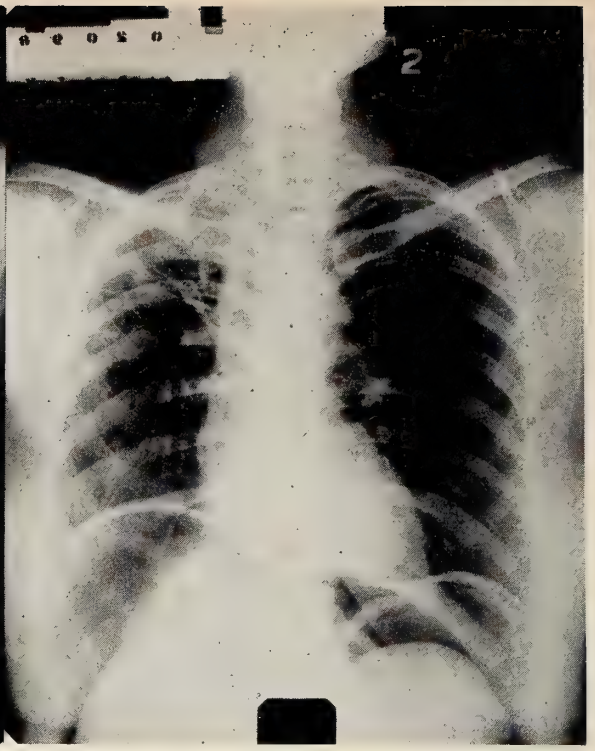


Figure 2b. After 8 months of chemotherapy and pneumoperitoneum at M.T.S., x-rays reveal stability of lesion with shrunken cavities. Surgery was advised but refused, and patient left hospital against medical advice, 2-2-53.

paper to discuss the use of thoracoplasty versus resection in the treatment of cavitary disease. It is important, however, that surgery be carried out at the appropriate time. To delay in the hope that the cavity will ultimately heal without surgery is to invite disaster.

In many cases, after six to twelve months of chemotherapy, the reversible portions of the lesion have healed very well and no cavities remain but there are solid residual areas visible on the x-ray. Opinions differ on the need for surgical removal of such solid residues. At M.T.S., it is considered best to resect solid residues provided the patient's general condition is satisfactory. There has been no mortality in sixty-one patients so treated.

Chest surgery under the protection of chemotherapy and performed by specialized personnel has become very safe. In the last 400 patients who have had thoracoplasties at M.T.S., the mortality rate has been 1.2% within three months. Of 274 resections, excluding pneumonectomies, the mortality rate was 1.5% within three months. The patients included many who were considered poor-risk cases. Pneumonectomy carries with it a greater hazard, depending largely upon the type of case accepted for operation.

HOW TO GAUGE THE PATIENT'S PROGRESS

While receiving chemotherapy, the large majority of patients are asymptomatic and sputum-negative. Serial x-rays therefore, serve as the main guide to be followed in determining the progress of the disease. Under chemotherapy, x-rays reveal progressive clearing of the reversible component of the disease. Most of this clearing occurs during the first six months of treatment but may continue to a lesser degree for some months longer. Maximal clearing is attained when the x-ray reveals nothing more than solid residues and cavitation. The determination of the presence or absence of cavity on x-rays has become a problem of prime importance in the management of pulmonary tuberculosis. To determine this point, special views such as lordotic, kyphotic, or laminagrams are frequently necessary.

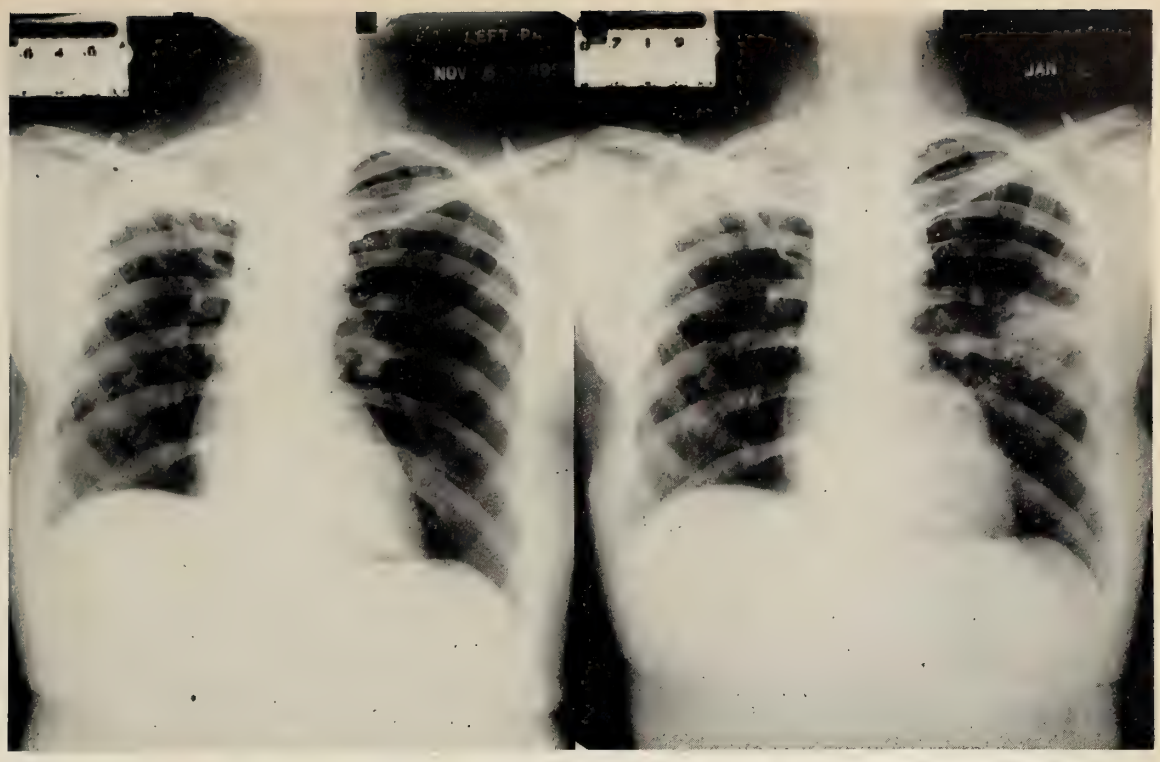


Figure 2c. Nov. 6, 1953, x-ray reveals little change, although patient stopped taking chemotherapy and pneumoperitoneum. Cavitation still present in right apex.

Figure 2d. Jan. 15, 1954. Patient has suffered a spread of the disease to the left mid-field making the prognosis much worse.

EFFECTIVENESS OF MEDICAL MANAGEMENT

Under the management outlined above, the large majority of patients become essentially asymptomatic after three or four months of treatment and x-rays show considerable clearing of the reversible portion of the lesions. At this time, sputum concentration tests are usually negative for tubercle bacilli although cultures may remain positive. After six months of treatment, the reversible portion of the patient's disease has usually cleared on x-rays, leaving behind evidence of solid caseous areas and cavitation. Cavities which were originally under 4 cm. in diameter are frequently lost to view by this time and may heal. Cavities which were originally over 4 cm. in diameter occasionally close but usually require surgical measures. Complete closure and healing of all cavities is the best insurance a patient can have against future relapse. (See Figure 1.) Persistence of open cavities results in the proliferation of drug-resistant tubercle bacilli and ultimate relapse of disease in over fifty per cent of such patients.[5] (See Figure 2.)

WHEN CAN THE PATIENT LEAVE THE SANITARIUM?

Formerly, it was considered advisable that all patients remain in the sanitarium until declared "inactive." Because of the shortage of hospital beds, M.T.S. has endeavored to discharge patients at an earlier period since March, 1953.[6] Carefully selected patients are discharged from the sanitarium as soon as they fulfill these conditions: (1) X-rays reveal marked improvement as shown by more than fifty per cent clearing of the lesions. (2) All cavities must have disappeared as indicated by special x-ray studies, including kyphotic and lordotic views, and laminagrams, if needed. (3) Repeated concentration tests are negative for tubercle bacilli. Patients receiving an early discharge are advised to rest at home and continue their chemotherapy and pneumoperitoneum at the outpatient clinics. The results of such an early discharge program have been excellent. In one year of experience with 500 patients, only one per cent showed x-ray evidence of relapse. The average hospital stay for this group was ten months.

Patients with persisting cavitation but negative on concentration tests while under chemotherapy should be retained in the sanitarium, if beds are available. There is a strong probability that many of these will turn positive and relapse later. Patients with persisting positive concentration tests require isolation, preferably in an institution.

DISCUSSION

The general pattern of management for pulmonary tuberculosis at M.T.S. consists of sanitarium care and chemotherapy with at least two anti-tuberculous drugs which will be continued without interruption for many months. After one month of chemotherapy, pneumoperitoneum is usually induced and continued. After six months of chemotherapy, the patient is carefully examined, with special x-rays, for the presence of cavitation. If cavitation persists, surgery is performed as soon as the patient is in condition to have it. Solid caseous foci which remain may or may not be resected. When the patient's cavities have been eliminated either by medical or surgical treatment and the sputum is negative, the patient is discharged from the institution to continue his chemotherapy at home. At M.T.S., about seventy-five per cent of those admitted fall into the latter group. Twenty-five per cent of those admitted show various degrees of failure. Many of these have extensive bilateral disease with cavitation and remain persistently positive over a period of years. Most of these ultimately die. Many become so-called good chronics. These are patients who become essentially asymptomatic with persisting cavitation and negative concentration tests while on chemotherapy. They may continue in this state of balance over a period of several years. If chemotherapy is discontinued, with or without over-exertion, malnutrition, or intercurrent infection, many of these patients suffer relapse and ultimately die. Such patients can by no stretch of the imagination be considered cured in spite of their clinical well-being for long periods of time.

Since the advent of isoniazid, some erroneous ideas concerning treatment have gained currency. One of these statements is to the effect that rest is no longer needed. This is untrue because rest is still an important part of the treatment of tuberculosis and is obviously necessary for the febrile or toxic patient. The use of chemotherapy shortens but does not eliminate the necessity for rest.

Another fallacy is based upon the assumption that cavities which persist after long chemotherapy are completely healed. Examinations of hundreds of resected specimens at M. T.S., however, have demonstrated that over ninety per cent of persisting cavities show gross and microscopic evidence of active tuberculosis and most of them have living tubercle bacilli within them. In only a small percentage of such cavities is the disease really healed. No method is available at present to determine whether the cavities seen on x-ray are healed or unhealed in the living patient except resection and pathological examination.

It is best to select a combination of drugs at the beginning of treatment and continue without interruption until no further chemotherapy is needed. Changing drugs encourages resistance of tubercle bacilli. Only under certain specific conditions should the treatment be changed. If the patient develops severe allergy to one of the drugs, it may be necessary to change to another. If pulmonary surgery is necessary or if tuberculous meningitis should occur in a patient who has resistant organisms, it becomes necessary to change the treatment. Patients who have received considerable chemotherapy with one combination of drugs rarely show much evidence of benefit on x-rays when changed to another combination.

SUMMARY

Good management of the patient with pulmonary tuberculosis requires a coordinated plan from the beginning of treatment. The best treatment requires sanitarium care with bedrest, modified to fit the individual case and followed by gradual rehabilitation. Prolonged chemotherapy should be started with two of the bacteriostatic drugs and should be continued without interruption or change for several months beyond the point at which the patient can be classified as inactive. Pneumoperitoneum treatment is valuable and should be started shortly after chemotherapy. Thoracoplasty or resection is needed for residual cavitation and should be considered after six to twelve months of chemotherapy, or as soon as stability has been established. Resection of large solid foci is elective and is preferable if a competent thoracic surgeon

and anesthesiologist are available. It should be kept clearly in mind that it is easy to produce spectacular results at the beginning of treatment but that the end result is what counts. A permanently cured patient is the desirable end. A cause of poor management, is not a credit to patient who improves, only to relapse later be- his physician.

REFERENCES

1. Lichtenstein, M. R., and Cannemeyer, W.: Severe Para-aminosalicylic Acid Hypersensitivity Simulating Mononucleosis or Hepatitis. J.A.M.A. 152,606 June 1953.
2. Cannemeyer, W., Thompson, J. R., and Lichtenstein, M. R.: Severe Para-aminosalicylic Acid Hypersensitivity — Blood and Lymph Node Studies. Blood 10, 62 Jan. 1955.
3. Brinkman, G. L., Raleigh, J., and Mitchell, R. S.: The Use of Pneumoperitoneum as an Adjunct to the Prolonged Streptomycin-Para-aminosalicylic Acid Treatment of Pulmonary Tuberculosis. Amer. Rev. Tbc. 69,963 June 1954.
4. Moyer, R. E. and Schwartz, W. S.: Results of the Addition of Pneumoperitoneum to Long-Term Chemotherapy of Tuberculosis. Trans. of 13th Conf. on Chemotherapy of Tb. pp. 154-157 February 1954.
5. Raleigh, J. W., D'Esopo, N. D., Osgood, C. K., and Campbell, A. M.: Relapse Following Chemotherapy for Pulmonary Tuberculosis. Trans. Nat. Tb. Assoc. 1954 p. 260.
6. Lichtenstein, M. R.: The Results of Antimicrobial Therapy Among Out-patients. Trans. Nat. Tb. Assoc. 1954, p. 301.

‹‹‹ ›››

Medicine and Citizenship

Ernest E. Irons, M.D., Chicago

WE are now emerging from an extremely dangerous social and political crisis, which resulted from years of failure of all of us to think things through, and to relate current trends to our national political and social past. The danger is not yet over, but we have a breathing spell in which we may look back over our national past, and thus gain some perspective to guide our future course. We shall see more clearly our earlier mistakes, which were not understood by the public nor by a substantial portion of the medical profession a few years ago.

Five years ago we were threatened with the imposition of socialized medicine. The medical profession was on the defensive on the front line of battle. But socialized medicine was only an early and indeed a minor part of the socialist program envisaged by those who would destroy the democracy of our republic. This is not an emotional outburst of an harrassed medical profession; it is an objective statement of fact long unrecognized by some of the other professions, and wishfully ignored by business men who disliked the prospect of further loss of profits and feared reprisals of a dictatorial administration. The origins and magnitude of the crisis were recognized by but few citizens.

I doubt whether the basic significance of the results of the 1952 election, or the origins of the crisis which underlay it are understood even now by the average voter. The election outcome was the result of joint efforts of serious minded democrats whose party had been betrayed by bad leadership into accepting socialistic doctrines, and of republicans whose platform and canidates in this election had a strong public appeal for national security and integrity. These democrats and republicans united in expressing their preference for patriotism rather than partisan politics.

OTHER NATIONAL CRISES

Once again the value of our two party system in a democratic system of government as a means of reaching a national conclusion was demonstrated. In past decades other minor party groups have come and gone. Some were parties of protest or more often of propaganda for proposals which favored some special economic or social project. They were transient but they contributed to the clarification of national issues dealt with by the two great parties.

Our first great national crisis followed the War of Independence and concerned the adoption of the Constitution in 1787. The varied and often conflicting geographic and economic

interests of the several colonies, as yet only partially accustomed to working together, occasioned violent debates. The outcome, our Constitution, is a lasting monument to the intelligence, the patriotism and foresight of the men of the Constitutional Convention.

The disestablishment of the United States Bank in 1837 was a political issue which, combined with unwise currency regulation and wild speculation in land, precipitated the financial panic of 1837.

The division of the country on the issues of states rights and slavery in 1857-61 resulted in the Civil War and loss of power by the democratic party. Republican injustices and abuse of power during post-war reconstruction, left scars which only now are beginning to fade.

The return to sound money, on the gold standard, with resumption of specie payments in 1873, and the later Free Silver versus Sound Money Campaign of 1896 presented other national crises, right decisions in which were fundamental to our national safety.

Each developed on the basis of sectional, social or economic desires and of widely divergent geographic differences which required decisions in keeping with the central purpose of national permanence, provided under the Constitution.

It is perhaps surprising and a little disturbing to note how many of these and other crises hinged primarily on honesty, financial and property rights, and sound money, although their immediate political appeals included also social and emotional arguments which tended to overshadow and obscure the basis issues. We all agree that social injustices should be corrected, but at the same time we recognize that as we correct them, our increasingly complex civilization creates new ones, real or fancied, which our forebears never even imagined. As in medicine, so in national policy, in our attempts to cure social ills we must guard against doing harm to our social and political structure on which depends the social progress we have already made.

REVERSALS OF PARTY PLATFORMS

Each great issue was espoused by one or the other of the two great parties; sometimes one, sometimes the other triumphed politically. Nor have the policies of either great party remained consistently continuous. Melville Fuller of Illinois later Chief Justice of the Supreme Court, himself a life long democrat, described the then doctrine of his party, "That all power not expressly delegated to the Federal Government remains with the states and with the people." Later as Chief Justice he saw the democratic convention stampeded to the nomination of Bryan, the apostle of free silver. Meanwhile by its actions the republican party had become politically vulnerable as the party of special privilege. Still later in the 1930's, a little over twenty years after Fuller's death, his party had again reversed itself under Franklin D. Roosevelt, and now urged a vast extension of federal powers, and by various means including direct and matching subsidies attempted to dominate the policies of the states. The Supreme Court held in 1942 that "the government may regulate that which it subsidizes."

Each party has acted as a check on the other and both have united on the main objective of representative government in the national interest. We even have had to change a constitutional amendment after the demonstration of its impracticability.

ORIGIN OF THE PRESENT CRISIS

With the exceptions of the difficulties in harmonizing the diverse interests encountered in the framing of the Constitution in 1787 and of the states rights and slavery issues of 1857-61, our nation has been confronted by no more serious crisis than that of 1952.

We had emerged from World War I technical victors, but with heavy indebtedness. Unlike our allies we had not suffered property loss by invasion. In the 1920's we engaged in a financial boom with its attendant impairment of moral values. We withstood the early stages of the world financial crash brought on by widespread war-time European destruction of property and the disorganization of the means of production, but in 1929, our own unstable financial state, created by wild speculation, engulfed us in the depression of the early '30's. Frugal people saw their life savings swept away. As unemployment increased the suffering of the people grew and they demanded a change.

The new president was a brilliant, astute politician, lacking in sound principles especially in financial matters, unscrupulous in matters affecting his political fortunes. He surrounded

himself and a compliant congressional majority with unsound advisors including some economists of restricted historical vision, who vacillated between an economy of scarcity with destruction of food supplies, and the stimulation of production by subsidies. Their recommendations, accepted and implemented by the president, led more and more toward subordination of principle to expediency. Sound but politically painful measures of recovery were brushed aside in favor of programs temporarily politically attractive which later were invalidated as unconstitutional by the U. S. Supreme Court. This opposition led to the petulant attempt by the president to purge congressional opponents and to pack the Supreme Court. Year after year bureaucracies grew. New curbs were placed on business and the freedom of citizens, in the attempt to replace free enterprize by a managed economy.

Our entry into World War II diverted attention for a time from our domestic errors, but political immorality later exposed us to diplomatic blunders from which we are still suffering. The political realignments incident to the war under an administration guided by expediency rather than by honesty and principle gave opportunity for the further infiltration of our government by socialists, communists and traitors. The lack of rugged honesty of administration leaders encouraged deviation from moral and ethical standards and we entered the era of mink coats and outright bribery. The respect of American citizens and of foreign nations for the high office of the President of the United States was impaired.

Meanwhile Marxists, full-fledged declared socialists as well as their satellite groups of fellow thinkers and intellectuals continued their plans for changing this government to that of a socialized state. As in early socialism in Germany, and later in England under the Fabians, medicine was singled out as the most vulnerable point of attack. Medicine, charged with the application of methods of prevention and cure of disease, was, by socialist propaganda, accused of unconcern for social and economic distress of the people, in the causation of which medicine had had no part. Faults in the quality of individual medical care were magnified and ascribed to the entire profession.

A stupendous interest-bearing debt of two wars, increased outlay for defense, government waste and inefficiency, the continuing intrusion by government in private enterprise, unsound manipulation of prices, an ever increasing taxation, and a growing popular distrust of governmental administration made the nation increasingly vulnerable to socialistic attacks. Socialists regarded the time as favorable for expanding their program of socialism. Both socialists and communists prefer to fish in muddy waters. They had enjoyed numerous successes for twenty years.

SOCIALISM IN AMERICA

Economic and social injustices on which Marx and Engels based their appeal in the Communist Manifesto, called for correction, but the remedies proposed were based on unsound and now discredited economics and atheistic thinking and resulted in a worsening of the social and economic conditions they were alleged to remedy. Communism, the ultimate stage of socialism, destructive of all individual incentive and effort and finally of liberty itself began to infiltrate the governments of Europe.

The doctrines of the Communist Manifesto were brought to America early in the 1880's and an unsuccessful attempt was made to establish class lines, and inter-class war essential to the progress of socialism. Justice Brewer recognized the danger of socialistic theories in an address on "The Scholar in Politics." Later, as Mr. Justice Brewer of the U. S. Supreme Court, he declared "The paternal theory of government is to me odious."

Again in 1895 Mr. Justice Field in an opinion concurring with the Chief Justice in holding the income tax law of 1894 unconstitutional, prophetically said "the present attack on capital is but the stepping stone to others, larger and more sweeping." He foresaw the national decadence which would surely follow the aligning of one class of citizens against another. Justice Fuller declared about the same time that "Paternalism with its constant intermeddling with individual freedom, has no place in a system which rests for its strength upon the self-reliant energies of the people."

But nobody listened and step by step under the guise of correcting social and economic faults the assault on the Constitution continued. Year after year brought new intrusions of

government into business and the private lives of citizens. We had seen socialism smother individual incentive and initiative in Europe. But we said, "It can't happen here." In recent years even some administration leaders began to doubt the wisdom of our headlong socialistic course but were unable to turn back, and so went along with their unseeing politically minded colleagues.

Many issues were involved in the political battle of 1952 — war and its heavy cost, government waste, severe taxation — but the central and all-important issue was that of the freedom of the individual citizen from socialistic governmental interference, and the maintenance of real democracy in our republic.

THE POLITICAL CAMPAIGN OF 1952

For almost all of us who engaged in the national campaign of 1952, entry of professional men and especially physicians into politics was theoretically and traditionally distasteful. It was a new experience for most of us. Up to ten years ago we had assumed that our place as physicians was in medicine, and that we ought as a profession to maintain the dignity of medicine by abstaining from political contests. Furthermore, we had never suspected how great is the power of medicine in moulding public opinion.

But the issue of national survival and with it the survival of all the professions was of compelling significance. Previous frustrations in our fragmentary attempts to preserve quality of medical performance only added to our determination now to meet the issue "head on."

After conference with the National Republican Committee in Washington, the three recent past-presidents of the American Medical Association under the chairmanship of Dr. Elmer Henderson of Louisville, and with Dr. Cline of San Francisco organized the National Professional Committee for Eisenhower and Nixon under the campaign direction of Whitaker and Baxter. To our medical committee were added past presidents of national associations of the American Bar, Pharmaceutical Manufacturers, Dentists, Accountants and the Society of Professional Engineers. Some were life long democrats, some republicans. Each state was organized under the direction of a physician as state chairman. He organized his state, districts and counties down to precincts and included in each, representatives of the other professions. Extreme care was taken that neither the American Medical Association nor any other national professional organization nor any state or county medical society should have any official connection with our committee. We recruited all professional men as individuals.

The final response to our appeal for campaign participation and for funds was most gratifying and enthusiastic, although in the beginning for a few days it appeared that we might have to underwrite our program ourselves. We carried through our program as originally planned and at the end were able to turn back contributions to the states for their own use, and had a surplus to help other national political groups.

All this was due to the wonderful response of all of you in Illinois as well as in the other states. To you belongs the credit.

Perhaps the most important factor in the success of our part in the campaign was the educational campaign of the previous three years under the direction of the Coordinating Committee of the American Medical Association, the funds for which were contributed by the physicians of this country. Organization-wise we profited also by the experience gained by the profession in the congressional campaigns of 1950. In 1950 physicians generally first came to appreciate their power.

And so in 1952 the socialistic downward trend in our government was stopped, at least temporarily, and we can now enter the long road back to the highway of the Constitution, the perpetuation of free enterprise, and increased emphasis on personal responsibility of each citizen.

But the road is long. Like the hoped for reduction in taxes, years will be required to correct the mistakes while retaining the good features of recent legislation. Nor is socialism or communism vanquished; they will soon resume the fight.

The immediate problems of medicine are merely a part, but an important part of the tremendous task of getting this nation back on the Constitutional highway. Socialistic programs disguised under attractive vote-getting titles offer to provide federal funds, (and federal intrusion) into state and local issues, and lead

citizens to look to a paternal government for help to do things which they can and should do for themselves.

Such programs are a deliberate continuation of previous infiltration of government by avowed Socialists reinforced by misguided persons and intellectuals who do not see the final destructive effects of their presently alluring proposals.

Medicine has made great progress not alone in utilizing the amazingly effective new life saving procedures, and also in a voluntary improvement of human relations between physicians and the public.

Here and there, the perennial fee splitting controversey appears. Human nature has not changed and there are always a few in every profession who forget their obligations, and attempt to profit at the expense of their fellows and patients.

The increased cost of medical care is less than the increase in cost of other necessities of life, but still is a serious problem for those struck down by illness. Hospital cost is a serious item, and like our other personal economic problems is a result of inflation, and of our 50 cent dollars. Voluntary insurance is growing rapidly, and goes far to ameliorate the financial tragedy of illness.

These and other similar ones, are problems in which physicians are largely concerned, but they are only a part of the much greater national crisis from which we are emerging. We must maintain our freedom as individual citizens, each doing his part and relying on his own efforts rather than demanding that his neighbor carry him. If we fail to accept each his own responsibility, we shall go down as have other socialist nations in history.

With this great task before us, this is no time for physicians to sit back and relax. We each have a duty as citizens to study issues and vote according to our opinions. As a profession we must never again let it be said that we have neglected our duty as citizens in the free democracy of our republic. Good professional performance can never absolve us from the obligation of good citizenship.

122 S Michigan Ave.

‹‹‹ ›››

The heart? It is good

The same contrast is seen in giving reassurance. A mother was told her baby had a heart murmur but there was nothing to worry about. Numerous explanations and repetitions had little effect in alleviating her anxiety. She harped on the subject of heart disease in every visit to the station; she asked innumerable questions and always left with a worried expression. One day an authoritarian type of physician was in attendance. He listened to her questions, placed the baby on the examining table, applied his stethoscope, then turned to her and said, accenting each word, "The heart? It is good." He then ushered mother and baby quickly out of the examining room and beckoned to the next patient. Apparently the mother was relieved. The reassurance was effective. *David M. Levy, M.D. Advice and Reassurance. Briefs, Jan.* 1955.

The Guthrie Stone I.

Frederick Stenn, M.D., Chicago

IN Washington Park, Chicago, there lies a grey-red oval boulder measuring 11 x 9 x 10 feet high and 5 feet wide bearing this inscription:

"To Samuel Guthrie, M.D.
(1782 — 1848)
Commemorating his discovery
of Choloroform"
"Erected by the Chicago Medical Society"

The rock was discovered in 1885 by Guthrie's grandson, Ossian, a geologist, who found it in Worth, Illinois. It apparently had been carried in the bosom of the Laurentide Glacier from the Washara region in Wisconsin some 250 miles northwest of Chicago. It originated from strata some 80 million years of age. Ossian had wished to set it up as a memorial to his grandfather. On April 15, 1903, a committee of the Chicago Medical Society composed of Drs. W. A. Evans, H. H. Brown, A. R. Raynolds, J. R. Pennington and Ossian Guthrie, requested the South Park Commissioners (Edward J. Rainey, Lyman A. Walton, Henry G. Foreman, Daniel F. Crilly and William Best) to accept the rock. The Park Commissioners agreed to accept it without inscription and to place it in Washington or Jackson Park. On July 23, 1903 the City Council granted a plot of land 25 feet square for the monument. On Sept. 21, 1904, Ossian Guthrie asked the Commissioners for a site at the lake front and his request was granted. Through the kindness of Dr. John B. Murphy and Henry C. Weaver and at the cost of $500, the rock was transported in 1904 by flat car to the 39th Street side track of the Western Indiana Railroad and then to the foot of Jackson Boulevard. But when the granite gift arrived Commissioner D. F. Crilly said "We don't want the stone. It is unsightly and there is no reason why we should be obliged to litter up any of the South Parks with it. If there is an injunction against the Board I suppose we shall have to take the matter to court. I wish they'd break the rock".

Accordingly, some 18 of the Commissioners' men rolled the rock into the street. The rock was then removed to Rush and Ohio Streets. "The trouble" according to an article in the Chicago Tribune, dated Dec. 26, 1905, "is, the South Park Commissioners don't want it. They managed to shoo away Mr. Guthrie several times when he appeared with his 40-ton rock, and at regular meetings they have expressed regret that Dr. Guthrie ever discovered chloroform".

But the Chicago Medical Society, led by Drs. Chas. F. Bacon and Frank X. Walls would agree to no other site than Grant Park. With the assistance of 15 laborers and the Guthrie family, the doctors secretly loaded the stone on a special truck and brought it to the foot of Jackson Boulevard on the night of Dec. 25, 1905. A score of policemen were at hand to thwart their plan. The medical men defended their rights by presenting an injuction against the Park's prohibition. The unwelcome Christmas present was then dumped adjacent to the Art Institute and two men were ordered to guard it all that night and this through a heavy rain. The Chicago newspapers were filled with the story of the coup. Four days later, Louis E. Sater, representative of the South Park Commissioners said (Chronicle 12-29-05) "What the Park Commissioners do not like is the underhanded methods that were resorted to by the Chicago Medical Society to get the boulder in place."

Judge Mack ordered out a counter injunction giving the Park Commissioners the right to do as they saw fit. Litigation was started involving the City of Chicago, the Chicago Medical Society and the South Park Commissioners. By 1909 an effort was made to appeal to the Supreme Court and by 1910, Judge Gibbons of the Circuit Court dismissed the case. Two years later the boulder was resting in Washington Park, not far from a similar boulder near which General Grant planted a tree in 1879.

Presented before The Society for Medical History, Chicago, January 19, 1955.

On May 9, 1925 the Woodlawn Kiwanis Club offered to place a bronze tablet on the stone reading:

"A memorial to Dr. Samuel Guthrie,
Discoverer of Chloroform, 1782-1848.

Chloroform, one of God's best gifts to His suffering children". But it was not until 1931 that the Board of Trustees of the Chicago Medical Society, James H. Hutton, N. S. Davis, III, J. V. Fowler, George Baxter and Hugh MacKechnie, succeeded in having the stone inscribed.

Setting up this medical monument consumed the effort of a half century but this is only a split second in the life of a rock that had seen lakes and rivers form and vary, that has witnessed the arrival and disappearance of many species of animals and plants, that was at hand to greet man when he first appeared on earth. This God-hewn rock is an ideal memorial because it can be moved. In its present location it stands seen, but almost unknown. Thousands pass it daily. Few appreciate it. I suggest that the chloroform rock be moved for a fifth time, and to such a site in Chicago as will benefit those who understand its significance.

The ideal location is in a medical center where a student can observe greatness in simplicity.

BIBLIOGRAPHY

Gratefully acknowledging the kind assistance of
Mrs. Esther Frazer, Chicago Medical Society
Mrs. G. T. Donoghue, Chicago Park District
Mr. Paul Angle, Chicago Historical District
Mr. Anthony A. Olis, Sanitary District of Chicago
Dr. Hugh McKechnie of Chicago, Illinois

‹‹‹ ›››

Samuel Guthrie II.

(1782 — 1848)

Physician, Inventor, Chemist, Farmer

Frederick Stenn, M.D., Chicago

JAMES GUTHRIE, descended from an old distinguished Scottish family, served in the Revolutionary War with his two sons, Joseph and Samuel. Samuel I was a physician whose oldest child, born in Brimfield, Massachusetts is the subject of this study. Samuel II learned medicine at the age of 18 from his father, who, at his death in 1818, bequeathed him a set of silver catheters and five volumes of Benjamin Rush's "Medical Inquiries and Observations". In 1804 Guthrie married Sybil Sexton of Smyrna, Chenango County, New York, and had like his father, four children, Alfred, Edwin, Harriet and Cynthia. It should be remarked here that Alfred moved to Chicago in 1845 and became important in engineering the Illinois-Michigan Canal and drafting the U. S. Steamboat Law. His son, Ossian, was known as the father of Chicago's drainage system. In 1810-11 Samuel Guthrie attended lectures at the College of Physicians and Surgeons of New York and in 1814-15 at the University of Pennsylvania.

In 1817 at the age of 35, he set up practice in Sacket's Harbor, Jefferson County, New York, a thriving business and military center on the eastern end of Lake Ontario. His mother, Pawling noted, had frequently been annoyed by discovering her flour barrels filled with human bones stored there by Guthrie. (Some 1700 soldiers killed in the war of 1812 were buried near the Guthrie household). He earned part of his living by cleaning and wiring skeletons. Shortly after Benjamin Waterhouse had vaccinated his children in 1800, Guthrie vaccinated himself and his cousin Sarah before attending a patient with the disease.

But the practice of medicine was only a part of his life. Cattle, sheep and hogs roamed about his 40-acre farm where he had an excellent vegetable garden, fine fruit trees and an out-

Presented before The Society for Medical History, Chicago, January 19, 1955.

standing vineyard. He experimented with new types of seeds such as the Chinese tree corn and the Roan potatoe. He raised a crop of French sugar beets and in 1830 tried to produce crystalline sugar from potatoes but succeeded in obtaining only potato molasses.

On his farm he built shops, a chemical laboratory, and an alcohol distillery. By 1817 he had set in operation a factory which produced 120,000 gallons of vinegar, 100,000 gallons of alcohol and 1200 pounds of potassium chlorate. He was proud of the pure oil of turpentine he manufactured. As early as 1807 he had patented percussion pellets of the size of mustard seeds composed of potassium chlorate and potassium nitrate. These pellets served as a priming or detonating powder that could precipitate an explosion by a mere blow. Ossian Guthrie related that he had to remove his shoes when playing in his grandfather's gun-powder laboratory. Samuel Guthrie escaped many near fatal explosions in this room. The water-proof percussion powder which he made was sold largely to hunters of Canada and the United States through his agents VanBuren, Wardell & Co. of New York. He was known also for his conversion of the old rifle flint-lock to a percussion or punch-lock type of gun. Little wonder then that the officers of nearby Fort Madison found his knowledge of ballistics helpful.

Guthrie was a worker who knew no rest, using methods as exact as pioneering conditions would permit and in this respect resembling his contemporaries, William Beaumont, Daniel Drake and Ephraim McDowell. He loved to hunt and fish, was good at whist and excellent with the violin, his favorite books, the Bible, Don Quixote, Gil Blas, and Rasselas. He disliked spending money on anything but chemical investigation but gave freely of his time to civic affairs in Sacket's Harbor, being a trustee of the local library, a school inspector, and an over-seer of the poor. Ossian described him as of medium stature, slender, slightly stooped, with the left side of his face distorted in later life from tic douleureux. His dress was careless, his demeanor modest. He seldom altered his decisions: when he said "no" he meant it. He was particularly proud of his mare that had served three generations of Guthries. By the last ten years of his life he was invalided. The death of his son Edwin on the Mexican battlefield in 1847 broke his desire to live, and he died the following year, just as the death of Revere in World War I did to his father, Sir William Osler.

From 1831 to 1832 Guthrie sent six contributions to the American Journal of Science and Arts. The one article on the discovery of chloroform is his title to the hall of immortals. Though he lived sixteen more years he was never heard of in scientific circles again. Semmelweiss, it will be recalled went into permanent silence after the publication of his "Etiology and Prophylaxis of Child-bed Fever."

On reading Benj. Silliman's Yale College Chemistry (vol. 2-page 20) Guthrie encountered the following description of chloric ether:

"Resembles an oil, color yellowish but when purified, sinks in water in distinct globules, which readily run together. Sp. Gr. at 45° : 1.22. By much agitation is diffused in water and partially dissolved imparting to the water its own peculiar taste which is sweetish, aromatic and agreeable. Taken internally it is stimulating and reviving . . its medicinal properties have not been ascertained but from its constitution and properties it is highly probable that it would be an active diffusive stimulant."

About July, 1831, Guthrie studied chloric ether, and the following report appeared in the American Journal of Science and Arts (21:64, Jan. 1832):

ART. VI New mode of preparing a spirituous solution of Chloric Ether; by Samuel Guthrie of Sacket's Harbor, N. Y.

Mr. Editor: — as the usual process for obtaining chloric ether for the solution in alcohol is both troublesome and expensive, and as from its lively and invigorating effects it may become an article of some value in the "Materia Medica", I have thought a portion of your readers might be gratified with the communication of a cheap and easy process for preparing it. I have therefore given one below, combining these advantages with unerring certainty in the result.

Into a clean copper still, put three pounds of chloride of lime and two gallons of well flavored alcohol, of sp. gr. .844, and distil. Watch the process, and when the product ceases to come highly sweet and aromatic, remove and cork it up closely in glass vessels. The remainder of the spirit should be distilled off for a new operation. These proportions are not essential — if more chloride of lime be used, the etherial product will be increased; nor is it necessary that the proof of the spirit should be very high, but I have commonly used the above proportions and proof, and have every reason to be satisfied with them. From the above

quantity I have usually obtained about one gallon of etherial spirit.*

By re-distilling the product from a great excess of chloride of lime, in a glass retort, in a water bath, a greatly concentrated solution will be obtained. This new product is caustic, and intensely sweet and aromatic. By distilling solution of chloric ether from carbonate of potash, the product is concentrated and refined. By distilling it from caustic potash, the ether is decomposed, and muriate of potash is thrown down, while the distilled product consists of alcohol.

During the last six months, a great number of persons have drunk of the solution of chloric ether in my laboratory, not only very freely but frequently to the point of intoxication; and so far as I have observed, it has appeared to be singularly grateful, both to the palate and stomach, producing promptly a lively flow of animal spirits, and consequent loquacity; and leaving, after its operation, little of that depression consequent to the use of ardent spirits. This free use of the article has been permitted, in order to ascertain the effect of it in full doses on the healthy subject; and thus to discover, as far as such trials would do, its probable value as a medicine. From the invariable agreeable effects of it on persons in health and the deliciousness of its flavor, it would seem to promise much as a remedy in cases requiring a safe, quick energetic, and palatable stimulus. For drinking, it requires an equal bulk of water.

REMARKS: Mr. Guthrie states in a letter to the editor, that his attention was called to this subject by the suggestion in Vol. II, page 20, of the Yale College Elements of Chemistry, that the alcoholic solution of the chloric ether is a grateful diffusive stimulant, and that as it admits of any degree of dilution, it may probably be introduced into medicine. Mr. Guthrie's method of preparing it is ingenious, economical and original, and the etherized spirit which he has forwarded as a sample, is exactly analogous, in sensible properties, to the solution made in the manner described in the above work. We shall take care to distribute portions among our medical friends for experiment, and as chlorine possesses so many peculiar powers, it is not impossible that this combination may prove curative or restorative, beyond what belongs to properties merely stimulating.

In this latter respect, Mr. Guthrie's experiments have certainly been quite sufficient; and we ought to discountenance any other than a medical use of this singular solution; unless indeed it should be found of utility in some of the arts. He would be no benefactor to his species, who should add a new attraction to intoxicating spirit.—Editor. Vol. XXI — No. 1

Professor Silliman was thus delighted and in Art. XI of the same journal wrote: "I add a notice of the following facts, communicated by Mr. Guthrie in his letters, not for publication but which I conceive are honorable to the rising arts of chemistry in this country. I presume it was little suspected that such things were doing in a remote region on the shore of Lake Ontario (Erie)".

(*The affinity of chlorine to lime, is so weak, and to alcohol so strong, that the chlorine is all taken up, long after the distillation is over; hence, the absolute necessity of watching the process, so as to know when to set aside the etherial portion). American Journal of Science and Arts, Vol. 21, pg. 64, Jan. 1832.

A Fernando Jones who was standing beside Guthrie, as he produced chloroform said, "You'll rue this day as long as you live". Guthrie thought he had isolated chloric ether. But his substance was quite different chemically and physiologically from the chloric ether obtained in 1796 by four Dutch chemists when they mixed ethylene with an equal quantity of chlorine gas over water, and obtained a dense, oily liquid. Justus von Liebig of Germany and Eugene Soubeiran of France both staked claims to the discovery of this so called chloric ether since they too isolated the same substance in 1832, and each ignorant of the investigations of the other. The fact remains that Guthrie had done his work some four months before that of his distinguished confreres. Guthrie had done his work about July '31, Soubeiran about Oct. '31 and Liebig about Nov. '31. The Edinburgh Medico-Chiurgical Society and the Chicago Medical Society in 1888 and again in 1903 gave priority to the American. The name of chloroform was proposed by Dumas in 1834.

Professor Silliman suggested to Eli Ives, professor of theory and practice at Yale, to try what was then called Guthrie's sweet whiskey on patients. On Jan. 2, 1832, Ives gave an half teaspoon every two hours for 12 hours to a 60 year old woman ill with severe asthma. By morning she was relieved. He also gave it by inhalation to a man dyspnoic from pulmonic disease: he was afforded a pleasant sleep.

Harriett, Guthrie's daughter, was surprised to observe several cats about the Guthrie household be put to sleep as they played about the chloroform vats. Then they would awaken and run off. The husband of Guthrie's housekeeper took a dose for his headache and slept two days and a night. Guthrie himself put a man to sleep while bystanders were convinced that he would never return to life. He also corrected the fractured arm of a seven-year old boy and in 1848 amputated a leg at Madison Barracks, under chloroform anaesthesia.

On Feb. 1, 1848, Guthrie wrote to his daughter: "I made the first particle (of chloroform) that was ever made and you are the first human being that ever used it in sickness. This is likely to prove the grandest discovery in medicine the world ever saw. By breathing it a few seconds the person falls apparently into a deep sleep — when breasts, legs and arms may be cut away, painful labors ended and all without pain or injury . . ."

When James Young Simpson announced his discovery of chloroform as a new anaesthetic agent on Nov. 10, 1847 at 52 Queen St., London, a new era in surgery and obstetrics had begun. The anaesthetic came in general favor when the world heard that Dr. John Snow had attended Queen Victoria in 1853 and delivered her eighth child, Prince Leopold, under chloroform. According to Irons, chloroform was first used in Chicago by Daniel Brainard at the City Dispensary on Jan. 24, 1847, ten days before it was introduced into New York City.

The story of chloroform illustrates a cardinal principle of medical history. Knowledge is so inter-related that no one part of it can stand by itself any more than an individual cell can function separately from the organism it composes. There could be no Billroth without a Simpson, no Simpson without a Guthrie, no Guthrie without a Paracelsus, no Paracelsus without an Empedocles. Knowledge grows from previously existing knowledge and progress is obtained by inching our paths forward. Few of us can be Guthries but all of us however poor be our talent, can push back the boundaries of the unknown in some little way.

BIBLIOGRAPHY

Guthrie, Ossian: Memoirs of Dr. Samuel Guthrie and the History of the Discovery of Chloroform and Anaesthesia. Chicago 1887. Hazlitt & Co.

Hatfield, M. D. Lest we forget. A tribute to the American Discoverer of chloroform. Chicago Clinic and Pure Water Journal, June 1905, and the Alumni Register, Univ. of Pennsylvania **10**: 204-8, 1905-06.

Hubbard, Oliver Payson: Notes on the discovery of chloroform. Trans. N. Y. Acad. Science **7**:149, 1897.

Simpson, James Y.: Works of Sir James Y. Simpson. Edited by Sir W. G. Simpson, 1912.

Silliman, Benj. Jr.: American Contributions to Chemistry. **5**: 86, 1874.

Robinson, Victor: Samuel Guthrie (1792-1848) Medical Life (Guthrie Number) Vol. 34, No. 3, Mar. 1927.

Robinson, Victor: Victory Over Pain, Schuman, N. Y. 1946.

Editorial: Samuel Guthrie: One Man Dupont Plant, Times, N. Y. 74, 139, May, 1946.

Smith, Daniel B.: On Certain Compounds of Carburetted Hydrogen, Journal of Philadelphia College of Pharmacy, Vol. **4**:116, 1832-1833.

Liebig, Justus Von: Ueber die Verbindungen, welche durch die Einwinkung des Chlors auf Alkohol, Aether, olbildenders Gas und Essiggeist entsehen. Annalen der Pharmacie **1**: 182, 1832.

Irons, E. E.: The Story of Rush Medical College. Pub. by the Board of Trustees of Rush Medical College, 1953.

Guthrie, Douglas: 1. A Hundred Years of Chloroform. Edinburgh Med. Journal **55**:246-51. Ap 1948. 2. Centenary of Chloroform. Brit: M.J. Nov. 1. p. 701-2, 1947.

Johnstone, R. W.: Sir James Young Simpson and Chloroform. Edinburgh Med. J. **54**:534-539, Oct. 1947.

Dumas, J. B. Recherches relatives a l'action du chlore sur l'alcohol. L'Institute **2**:106-108, 112-115, 1834.

Soubeiran, Eugene: Recherches sur auelques combinations du chlore Ann. de Chim. **48**:113-157, 1831. J. de Pharm. **17**:659-672, 1831 and **18**:1-24, 1832.

Keys, Thomas E.: The History of Surgical Anaesthesia. Schuman's, N. Y. 1945.

Pawling, Jesse R.: Dr. Samuel Guthrie and the Discovery of Chloroform, Northern New York Med. Jour. **3**:19, April 1946.

Pawling, Jesse R.: Dr. Samuel Guthrie, Discoverer of Chloroform. Brewster Press Watertown, N. Y., 1947.

Editorial: American Chemist. Aug.-Sept. 1874, p. 86-87, Centennial of Chemistry, Article on Samuel Guthrie.

Guthrie, Samuel: Original articles. American Journal of Sciences and Arts. 1. Vol. 21, p. 65—date of July, 1831. 2. Vol. 21, p. 295—Sept. 12, 1831. 3. Vol. 21, p. 407—Dec. 24, 1831. 4. Vol. 22—Feb. 15, 1832.

CASE REPORTS



Power Lawn Mower Decortication of Scalp and Skull

M. E. Kurth, M.D.; R. J. Drever, M.D., Chicago, and Charles Baran, M.D., South Bend, Indiana

MANY modern technological advances carry with them a hidden price in mangled limbs and maimed bodies. The simple and efficient power lawn mower has eliminated much of the drudgery of an onerous chore, but it has been responsible for an appreciable number and variety of multilating injuries, particularly of the lower extremities, ranging from amputation of the great toe to avulsion of the Achilles tendon.

V. M. Iovine[1] in a recent review of the various types of injuries resulting from high speed rotary lawn mowers, describes two principal forms (1) amputation, usually of a digit or the dorsum of the forefoot and (2) missile or shrapnel-like injuries from fragmentation of a blade when striking a hard, fixed object capable of producing severe compound fractures of the leg or extensive disruptions of soft tissues. He states succintly: "As a direct shearing force this instrument has no trouble amputating human flesh and bone". This observation is amply borne out in the present case report.

In a survey of the literature to date no similar instance has been discovered of a power lawn mower injury associated with decortication of scalp and skull. The more exposed and vulnerable lower extremities have borne the brunt of such injuries. The following case report was prompted by the unique site of trauma, the freakish nature of the accident, and the virtual freedom of the patient from discomfort, complications, or residual disability.

On June 18, 1954, a normal, healthy, well developed 11 year old boy on vacation was dozing peacefully with his close-cropped head on a relative's front lawn while two younger playmates were "manipulating" a gasoline engine lawn mower. One of the boys was instructing the other in the intricacies of its operation when the machine went out of control and passed over the head of the sleeping boy. As a result the right parietal area was shredded and partially avulsed and a small segment of the right parietal bone was removed, without penetration of the dura mater. It is more than likely that if the boy's hair had been longer, the injuries would have been more extensive, even fatal, if the longitudinal venous sinus had been torn. No severe degree of pain, shock, bleeding, subsequent loss of consciousness, or neurologic disturbance occurred. The boy was taken quickly to the local hospital for emergency care with a pressure dressing over the wound.

Dr. Charles Baran of South Bend, Ind., a



Figure 1. Skull x-ray revealing rectangular-shaped right parietal bone defect.

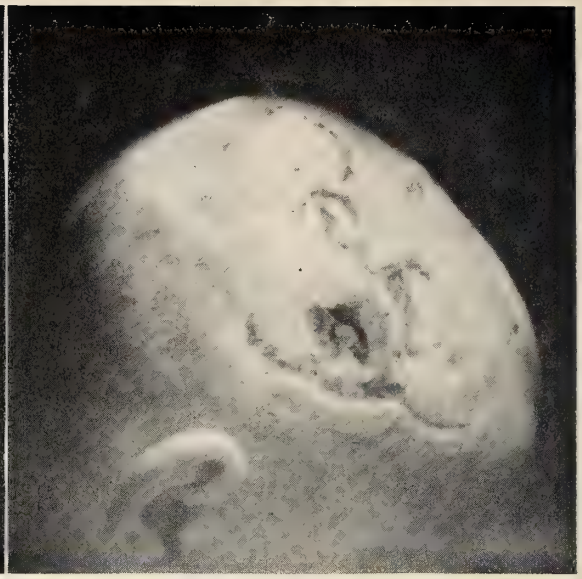


Figure 2. Appearance of scalp almost two weeks after injury before skin-grafting. Note exposed bone in mid-posterior defect.

neurosurgeon, who initially treated him, stated: "Injuries consisted of a scalp avulsion on the right side. The avulsed area was oval in shape and measured about three by four inches. There were two strips about one and a half centimeter in width. The remainder of the area was completely denuded of skin to the bone. In the middle of the area, the blade sheared the outer table of the skull. In one area one and a third centimeters in diameter the bone was completely sheared down to the dura, but amazingly enough the dura was not penetrated. The remainder of the avulsed area was approximated by replacing the two strip pieces and approximating edges of remaining flaps by mobilizing the scalp. After this was done there were two or three denuded areas measuring the size of a quarter which had no scalp or skin covering."

Tetanus antitoxin, antigas gangrene serum, and antibiotics were administered prophylactically and no untoward symptoms developed postoperatively. In a week or so, the boy's condition was so satisfactory he was transferred nearer home to a Chicago hospital where coverage of the scalp defects was undertaken. When first seen here, three irregularly shaped scalp defects were present in the right parietal region, the two anterior ones being separated by a questionably viable scalp flap, which later become necrotic (Figure 2).

The x-ray report by Dr. E. K. Lewis states. "Examination of the skull shows a rectangular shaped bone defect in the right parietal bone measuring 3 x 1½ cm. due to fracture with loss of bone substance. There is no evidence of fragmentation or depression. Bony structures are otherwise negative." (Figure 1).

To prepare the denuded areas for grafting by promoting granulation tissue formation, continuous warm, moist boric compresses were employed during the day with aureomycin ointment dressing at night (Figure 3). On July 12, 1954, under endotracheal anesthesia, a split-thickness dermatome graft, removed from the abdomen, was applied to the denuded area. Previously the exuberant granulations had been trimmed and the necrotic scalp flap removed, thereby converting the three separate areas into a single T-shaped one. Circumferential silk sutures were left long and tied over a bolster type pressure dressing of fluffed sponges overlying aureomycin ointment gauze. All of this was further secured to the shaved head with elastroplast. The postoperative course was uneventful. The initial dressing change on the eighth postoperative day revealed a complete "take" of the graft (Figure 4) the donor area epithelializing in about 2 to 3 weeks.

The grafted area will not bear hair. If this is objectionable to the patient the possibility



Figure 3. Pre-operative view of scalp after preparing area for grafting. Note necrotic scalp flap which was debrided.



Figure 4. Completely healed scalp showing irregularly contoured skin graft 10 days post-operatively and over one month after injury.

may be considered of its subsequent excision in 8 to 12 months with closure by local shifting of scalp flaps or multiple, partial excisions. However, the patch should contract somewhat and will be covered by the surrounding hair.

Repeat skull x-rays in 6 to 8 months may reveal some reduction in size of the bone defect, which was partially covered with a periosteal flap. Except for a direct penetrating injury, the relatively small pulsating cranial defect should not represent a serious problem or hazard in ordinary everyday life. Football, wrestling, or other rough contact sports would be interdicted, however, and special protective headgear may be worn when occasion demands.

SUMMARY

A case is herein presented of accidental, power lawn mower decortication of the right parietal scalp and bone, without dural penetration, in an 11 year old boy with delayed coverage of the denuded area by a split-thickness graft and uneventful recovery without neurologic residues.

25 E. Washington St. (Dr. Kurth)

REFERENCE

1. V. M. Iovine: High Speed Rotary Lawn Mower Injuries, GP. 10:51; July, 1954.

‹‹‹ ›››

SNAFU

The last 25 years have flooded us with alphabetic agencies, and he is indeed a dolt who doesn't understand UN- WHO, UNESCO, etc. The Armed Forces gave us a goodly number of useful alphabetics: SOP for Standard Operating Procedure (quite reminiscent of the s.o.b. that appears on clinical histories to indicate short of breath — beware of capitalizing these letters, though) and SNAFU for Situation Normal, All Fouled Up. Now a friend of ours declares he is working for his BMD. We were unable to equate this with any degrees we'd heard of and were wondering whether it had to do with a new telescoped type of Bachelor-Doctor of Medicine when he gave us the literal translation: Big Mahogony Desk. *Editorial. BMD. Minnesota Med. May* 1955.

Cat Scratch Disease

Irving Rudman, M.D. and John R. Cummings, M.D., Frankfort

THE first published account of cat scratch disease appeared in the United States literature in 1951.[1] Since then, many reports have followed to establish the validity of this clinical entity. It is probably of fairly common occurrence, although its recognition may be difficult when the characteristic features are not prominent. Moreover it is a disease of protean manifestations which further accentuates the diagnostic problem.[2]

Briefly, the usual clinical picture includes the history of a cat scratch which is followed in two or three weeks by a full-blown regional lymphadenitis without lymphangitis. The original site of injury frequently develops an inflammatory inoculation-type reaction prior to the onset of adenitis. The lymphadenopathy may subside spontaneously or progress to suppuration after a variable length of time. The disease is self-limited and non fatal. The diagnosis can be made most accurately by skin-test, using antigen prepared from pus obtained from suppurative cases.

This case report is presented to illustrate the perplexing clinical problem that may exist when the diagnosis does not immediately suggest itself.

The patient was an eight year old white male who was first seen three days after the onset of malaise, fever and pain in the right calf. The only pertinent history related to frequent minor cuts and abrasions of the lower limb in past weeks, including two cat scratches of the lower right calf which were incurred 18 days before becoming ill. These had all healed promptly and without local reaction.

The physical examination was negative except for the following findings: Temperature was 101 degrees (oral). There were several enlarged tender nodes in the right femoral triangle. There was a four by two centimeter, firm, tender mass associated with the proximal portion of the right gastrocnemius muscle without overlying skin changes. Dorsiflexion of the foot produced pain in the region of the mass. There were several healed scars in various areas of the lower leg. None were visible in the calf region. There was no evidence of lymphangitis.

From the Hedges Clinic, Frankfort, Illinois

Although the femoral adenitis subsided within three days, there was no other change in the clinical picture, despite four days of Gantrisin and three days of Erythromycin therapy. At this time, the white blood count was 10,400. One week later it was 8600. Neither the fever nor the limb findings responded to splinting of the knee with plaster for one week.

Three weeks after onset of the illness, the patient was hospitalized, his condition essentially unchanged. The sedimentation rate was 24 mm. Electrocardiogram, chest x-ray, tuberculosis patch test and three blood cultures were negative. For the first time, the patient became afebrile on bed rest, but the popliteal mass persisted.

Four weeks after the illness began, the mass was explored and found to be an abscess cavity in the proximal portion of the gastrocnemius, containing a cheesy exudate and necrotic bits of tissue. (Previous needle aspiration of the mass had been unproductive.) The cavity was excised, the area drained and the wound closed. The patient made a rapid uneventful recovery although his temperature occasionally rose as high as 100 degrees (oral) for two weeks.

The pus obtained at operation was cultured for aerobic, anaerobic and tuberculosis bacteria, as well as fungi. No growth developed. The biopsy tissue of the cavity wall was too fragmented to permit histological identification.

Eight weeks after the onset of the first symptoms, the patient was skin-tested with three antigens prepared from previous proven cases of cat scratch disease. There developed strongly positive reactions to two of the three antigens within 72 hours. There was no response to the third.

SUMMARY

A case of cat scratch disease has been presented in which suppurative adenitis occurred. The diagnosis was confirmed by skin-test with specific antigen.

The authors are grateful to Dr. Foshay of Cincinnati and Drs. Daniels and MacMurray of Washington, D.C. for their kindness in providing the antigens for skin-testing.

BIBLIOGRAPHY

1. Greer and Keefer: New England J. Med. 244: 545, 1951.
2. Daniels and MacMurray: Journal of A.M.A. 154: 1247, 1954.

EDITORIALS

The wonder drugs

The sulfonamides and antibiotics have revolutionized the practice of medicine during the past 20 years. Many diseases such as lobar pneumonia, purulent meningitis, mastoiditis, puerperal sepsis, and venereal diseases are vanishing gradually from the autopsy room. At the University of Chicago Clinics, for example, between 1927 and 1940, 50 deaths were attributed to lobar pneumonia in 2,000 consecutive autopsies; from 1940 to 1953 there were only seven. Deaths from purulent meningitis dropped from 61 to six; and those from perforated appendicitis, from 17 to two. One was a 2 year old child and the other, a 72 year old diabetic; neither had been given an antibiotic.

Meanwhile, there is considerable speculation about these drugs. Their widespread usage had led to numerous warnings concerning the greater frequency of drug reactions and a rise in the population of antibiotic resistant organisms. Reference is made to the increasing incidence of infections due to the streptococcus, fungus, and pseudomonas. "Hospital staphylococci" represent but one example.

In all probability these organisms have emerged as a result of our interference with their normal competitive environment, which removed the usual restraints characteristic of bacterial antagonisms. But whether they are more pathogenic than their less resistant brethren never has been established.

Nevertheless, none of us cares to turn back to the preantibiotic era. While some physicians have a pharmaceutical trigger finger and order penicillin or aureomycin indiscriminately, the majority are more judicious. They prescribe intelligently when a clear cut indication exists, regardless of potential side effects. So long as the organisms are not resistant to all antibiotics there is no need for apprehension. Moreover, the morbidity and mortality results speak for themselves. Infections are on the decline. Complications such as mastoiditis and peritonitis are less prevalent; neurosyphilis and cardiovascular syphilis seldom are encountered nowadays; and the lives of millions of people have been prolonged through the use of these drugs.

The most interesting speculation is concerned with the future. Will bacteria disappear entirely with the continued use of these products? So far, there is no indication that they will vanish, even though fewer streptococci are being spewed into the air and fewer gonococci and treponema are encountered. The small reservoirs that remain will continue to supply a source for future infections.

‹ ›

The polio lesson

The strangest thing about the polio vaccine mixup is that the motives of pretty nearly everybody concerned in the matter were altruistic. Nobody was trying to make small children sick and everybody was eager to keep them healthy. Nobody was trying to make a quick fortune from the vaccine. Nobody was trying to take credit for somebody else's achievement.

And yet the high hopes have been more or less disappointed and the program of vaccinating all the children of the first and second grades

clear across the country has been largely abandoned. Why?

The July number of the Journal of Pediatrics offers its answer:

> "Had the vaccine been developed and introduced for general use in the customary way, slowly and with carefully controlled studies, the end result might have been the same, whatever it may eventually turn out to be. The public, however, would not have been plunged from a pinnacle of great expectations to the depths of fear and confusion in a space of less than a month. The blame will unjustly be placed on the medical profession and not, in our opinion, where it chiefly belongs. . . ."

The editor gives the Foundation for Infantile Paralysis credit for aiding the research and arranging the mass experiment of 1954 but charges it with submitting the report of Dr. Francis at Ann Arbor "for public acclaim and not for careful scientific scrutiny, study, and criticism."

The editorial then sounds a warning that deserves the widest circulation:

> "What makes us truly apprenhensive is the fact that there are numerous other 'fund for a disease' organizations. Seeing the financial success of the polio foundation publicity experts, what is to prevent others from adopting similar methods? There are other diseases far more common and far more dangerous in their crippling and death rates than polio, as, for example, rheumatic fever and cancer. Think what would happen if a similar publicity stunt were developed for a promising experimental cancer cure."

The polio vaccine story teaches the moral that even altruism—the wholesouled desire to do good to others—must be disciplined. It must be restrained by the intelligence lest it fall victim to wishful thinking. It must be restrained also by the voice of experience, which can very readily be distinguished from the voices of fund raisers and their press agents.

Chicago Tribune, July 13, 1955

‹ ›

Part of human nature resents change, loves equilibrium, while another part welcomes novelty, loves the excitement of disequilibrium. There is no formula for the resolution of this tug-of-war, but it is obvious that absolute surrender to either of them invites disaster. — *J. Bartlet Brebner*

Section officers for 1956 annual meeting

At the 1955 annual meeting in Chicago last May, the following physicians were selected by the various Sections to plan the scientific programs for the 1956 annual meeting at the Hotel Sherman May 15, 16, 17, 18.

This group will meet in the fall with the President, the President-Elect, the Chairman of the Council and the Secretary. Definite half-day schedules will be developed for the 12 sections. An Executive Committee will be elected from the personnel of the "Committee on Scientific Work" to plan the scientific programs for the General Assemblies to be held on Tuesday, Wednesday, and Thursday afternoons.

By the first of the year plans should be shaping up — out-of-state guest speakers will be scheduled as guests of the various Sections and to speak before the General Assemblies. If you have suggestions to make relative to any of these Section Programs, or suggestions which you feel would improve the over-all picture of your state society meeting, contact the officers of the Section in which you are interested.

A successful annual meeting necessitates a long range planning program. The more Illinois physicians interested in the scientific presentations, the better the opportunity to offer the membership an outstanding scientific program in which they will all be interested.

The 1956 Section Officers are as follows:

SECTION ON ALLERGY:

Chairman: Milton M. Mosko, 55 East Washington Street, Chicago

Secretary: Leonard Harris, 1231 Jefferson Building, Peoria

SECTION ON ANESTHESIOLOGY:

Chairman: Arthur T. Shima, 532 N. Oak Park Avenue, Oak Park

Secretary: E. M. Dewhirst, 607 North Logan Avenue, Danville

Alternate: Mary Karp, 250 East Superior Street, Chicago

SECTION ON CARDIOVASCULAR DISEASE:

Chairman: Chauncey C. Maher, 6 North Michigan Avenue, Chicago

Secretary: Malcolm Spencer, 605 N. Logan Ave., Danville

(*Continued on Page* 127)



r retiring president, Arkell M. Vaughn, has just turned over the gavel l the microphone to F. Garm Norbury, his successor. Dr. Norbury's narks brought the business sessions to a close.

Pictorial report on the 1955 annual meeting

More than 3500 physicians, students and guests registered for the meeting in the Hotel Sherman, Chicago, on May 17-20. A remodeled mezzanine permitted more exhibit and luncheon space, and added to the comfort of the meeting.

Chicago will be the host city for the next three years. If you missed this one, here are pictures of some of the happenings.









Final Council luncheon brought many surprises. (left above) E. A. Piszczek, Chicago, thought no one knew it was his birthday. Joseph T. O'Neill, Ottawa, presented Arkell M. Vaughn a watch as a gift from the Council. He was in turn presented with a humorous badge by Jacob E. Reisch, Springfield. His laughter stopped when Burtis E. Montgomery gave him a lapel watch. Dr. O'Neill was reelected chairman of the council for a second term.

Photos above courtesy H. K. Moulton, M.D.
Those below and on following pages are staff photos.

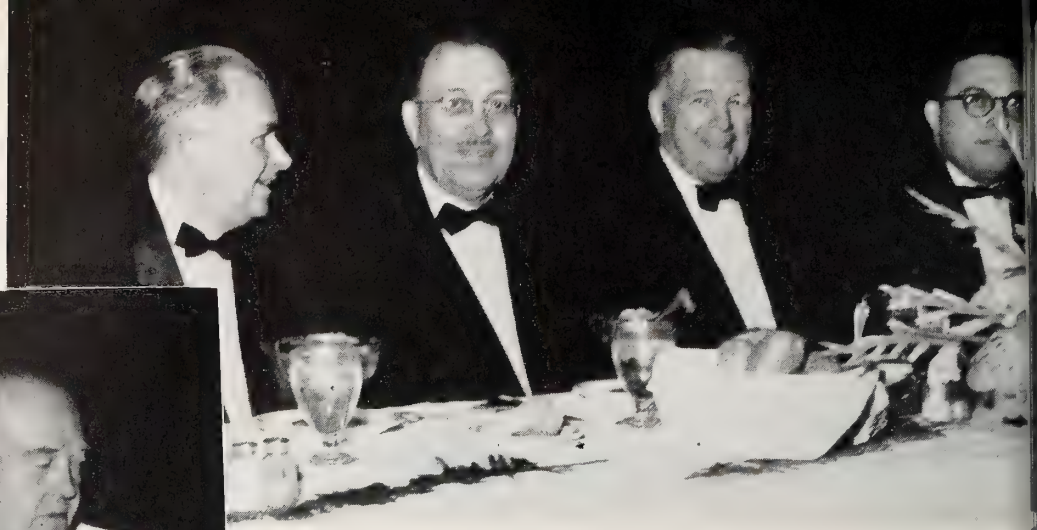


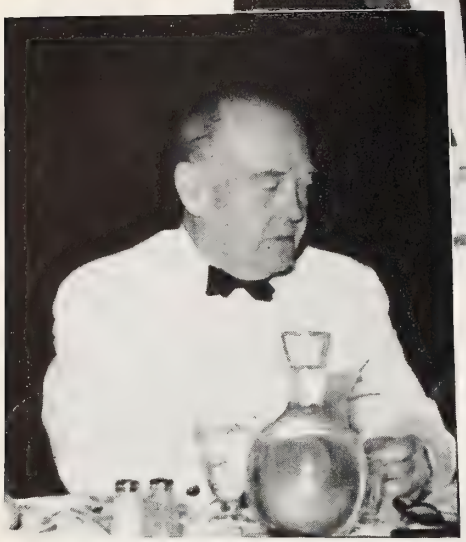


The Women's Auxiliary held a successful three day meeting in conjunction with the Society. (Left to right) Mrs. Albert Kwedar, Springfield, retiring president, Mrs. Warren Young,

Jacob E. Reich congratulates Ceaser Portes, Chicago, (right) upon his election to the Council. He was the only change in the Council lineup made during the annual meeting. He re-

The annual dinner





A large crowd jammed the grand ballroom of the Sherman for the annua dinner honoring the retiring president, Arkell M. Vaughn. The principa speaker was Clarence Manion, (left) former dean of the law school o Notre Dame University, South Bend, Indiana. His subject was "The Con stitution — America's Certificate of Public Health". Among those at th speakers' table were Patrick H. McNulty, the chairman of the dinne committee, Edwin S. Hamilton, George F. Lull and Louis R. Limarz



F. Lee Stone and Mrs. Stone received congratulations from Percy E. Hopkins upon the former's becoming president-elect. Dr. Hopkins is a past president of the Society.



M. R. Saxon, Oswego, delegate from the reorganized Kendall County Medical Society, talks with Coye C. Mason. Dr. Mason again served as director of the scientific exhibits.

(below) Awaiting the start of the annual dinner are Mrs. James H. Hutton, Mrs. F. W. Slobe, Dr. Slobe of Chicago, and Mrs. Everett P. Coleman of Canton





(above) Mrs. Joseph S. Lundholm and Mrs. Norman Sheehe of Rockford with the new president, F. Garm Norbury

Speakers



Alton Ochsner, chairman of the Department of Surgery, Tulane University, Louisiana School of Medicine, New Orleans, delivered the Oration in Surgery. Subject: "The Present Day Concepts in the Treatment of Veinous Thrombosis".

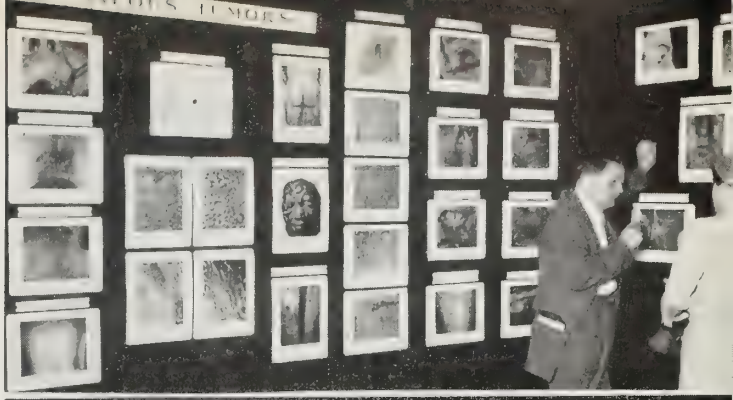


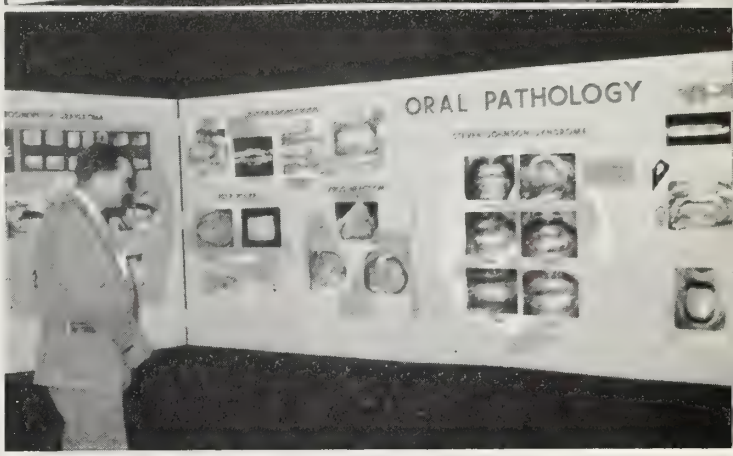
The Oration in Medicine was given by Thomas Francis, Jr., of the University of Michigan, School of Public Health at Ann Arbor. His subject — "Virus Problems in Medicine".



Mr. Edward Klinger of the Evansville Press addressed the public relations dinner on "Medical Press Relations from a Newspaper Man's Viewpoint". Mr. Tom Hendricks of the A.M.A. (below right) addressed the same group. With him is Harold M. Camp, secretary of our state society.







Scientific exhibits

The best exhibits in years produced the following winners: For educational value — a gold medal to Julius E. Ginsberg of the Northwestern University Medical School for "Cutaneous Tumors" (top) A silver medal to A. G. Anderson, M. Marvin Weiss and I. Harris, of the Veterans Administration Hospital for "Oral Pathology" (bottom above)

For original work, a gold medal went to William L. Riker, Arthur DeBoer, Thomas Baffes and W. J. Potts of the Childrens Memorial Hospital of Chicago, for "Surgical Treatment of Congenital Cardiovascular Anomalies", and a silver medal went to Frank Netter and Hans Popper of the Hektoen Institute for Medical Research of Cook County Hospital for "Illustrations of the Liver in Health and Disease". (Below)





The 50 Year Club Luncheon



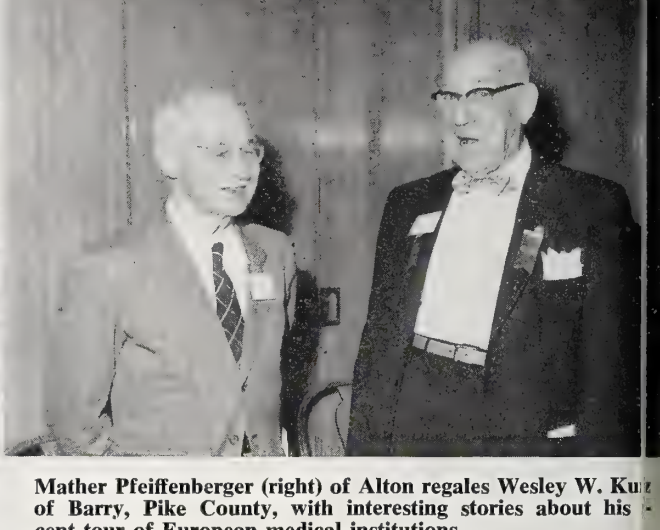
Among more than 150 attending the annual Fifty Year Club Luncheon were J. Prendergast, G. H. Mamen, A. E. Dennison and E. M. Hill. All are graduates of Rush in the class of '94 except Dr. Dennison, who was in the class of '95. Dr. Hill is a poet of considerable ability.



At the speakers' table — Julius H. Hess, D. Coggeshall, An Hall and A. L. Lowe, Jr. Dr. Lowe was given his certificate this luncheon. Dr. Hall continues to head this active and thusiastic group.



John W. Long of Robinson, J. W. Kirk of Oblong, A. L. Lowe of Robinson and H. N. Rafferty of Sebring, Florida. Dr. Rafferty practiced in Robinson and returned to see old friends.



Mather Pfeiffenberger (right) of Alton regales Wesley W. Ku of Barry, Pike County, with interesting stories about his cent tour of European medical institutions.

The Womans Auxiliary Luncheon



Mrs. James P. Symonds and Mrs. Thomas Oscar Freeman. The latter was given an award in appreciation of her services to education in the state. She is a past president of the Auxiliary.



Mrs. Darrell H. Trumpe, Springfield, served as general ch man for the convention. Mrs. Leonard Houda, Chicago, co-chairman, and Mrs. Maurice Hoeltgen was chairman the president's luncheon on the last day of their meeting.

Technical exhibitors



More than 70 companies serving the medical profession exhibited at the meeting. Most exhibitors were pleased with the attendance. After the flash of the bulb we learned that R. C.



Dalka of Chicago (with back to camera in picture at right) and one of the detail men, were almost as interested in photography as in medicine.

ection Officers (continued)

SECTION ON EYE EAR NOSE AND THROAT:

Chairman: Fletcher Austin, 700 North Michigan Avenue, Chicago

Secretary: G. L. Porter, 602 West University Avenue, Urbana

SECTION ON OBSTETRICS & GYNECOLOGY:

Chairman: Charles D. Krause, 1700 West 87th Street, Chicago

Secretary: Carl Greenstein, 207 W. University Avenue, Champaign

SECTION ON PATHOLOGY:

Chairman: Jerry J. Kearns, 3432 West Jackson Blvd., Chicago

Secretary: Frederick Bauer, 1439 S. Michigan Avenue, Chicago

SECTION ON PEDIATRICS:

Chairman: J. Keller Mack, 614 South 7th Street, Springfield

Secretary: Noel G. Shaw, 636 Church Street, Evanston

SECTION ON PREVENTIVE MEDICINE & PUBLIC HEALTH:

Chairman: Fred Long, 419 Fulton Street, Peoria

Secretary: Herbert Ratner, 129 Lake Street, Oak Park

SECTION ON RADIOLOGY:

Chairman: Fred H. Decker, Methodist Hospital, Peoria

Secretary: Hildegarde A. Schorsch, Cook County Hospital, 1825 West Harrison Street, Chicago

SECTION ON SURGERY:

Chairman: Cornelius M. Annan, 1180 East 63rd Street, Chicago

Secretary: David A Bennett, Coleman Clinic, Canton

By planning early, a better scientific program can be arranged for the next annual meeting. More time can be devoted to careful selection of speakers and papers. Physicians desiring to present papers at the next annual meeting should notify the State Society Secretary, who in turn, will submit the requests to the Executive Committee to be selected by the Section Officers early in the fall.

It is desirable in making such a request, to mention the subject the physician desires to present, and also a short synopsis of the subject matter to better enable the Executive Committee to make their selections wisely. By submitting this information in the near future, the work of the Committee on Scientific Work, composed of the various Section Officers can get under way after their meeting early in October.

John R. Wolff, Chairman, Walter C. Bornemeier, Edward W. Cannady, Roland R. Cross, Jr., E. F. Dietrich, W. W. Fullerton, Edwin F. Hirsch, Frederic T. Jung, W. R. Malony, Caesar Portes, William Requarth, Frederick W. Slobe.

Purposeful Living

Edwin F. Hirsch, M.D., Chicago

A WISE scribe of Memphis more than 3000 years B.C. wrote in Egyptian symbols "a man who does the things loved will live, and a man who does things hated shall die". This translation probably expresses the true meaning of the hieroglyphic message because other scribes of many succeeding generations of human life have recorded similar sentiments, none better or more beautifully stated than is in the words of the 13th chapter of I Corinthians "If I speak in the tongues of men and of angels and have not love, I am nothing."

The mutual affection between friends and the genuine respect that exists between lovers have been recorded through the ages in poetry and prose, in song and through other forms of music, in art, by sculpture and in drama; in fact, by every medium that man has used to express his feelings.

The connotation in my use of this simple word "love" is that of a reverend regard for man and his Creator, out of which a life, guided by these principles can develop a great strength of purpose and realize the benefits of purposeful living.

Men and women need more than medicine or surgery for emotional and physical health. Doctor Richard C. Cabot, a skilled physician, prescribed four guiding principles; work, play, love and worship as a formula for emotional health during the entire span of life. Real life, if it is to mean a nourishing, sustaining and developing existence demands work, play, love and so much of the material requirements of existence as to make them possible. Everyone should be, and desires to be, emotionally and physically healthy.

From the earliest times the primary purpose in the practice of the healing arts, has been to heal the sick. Why should the sick desire, above all else, to be well? This poses a basic question in the philosophy of life itself. It stems from the primary principle that each one of us has the fundamental hope to live and to achieve his or her quota of happiness and satisfaction in a life of purpose. Health of mind and of body are important when we strive to achieve this goal. Albert Schweitzer the philosopher, the theologian, the organist, and the humanitarian physician has emphasized clearly the fundamentals of this philosophy. He says, the most immediate fact of our consciousness is a will-to-live with others who also will-to-live. This concept of a will-to-live with others having the same purpose, enters into all forms of evaluation of ourselves and of the world about us. When we bid this will-to-live to a will-not-to-live, as occurs in all pessimistic thought, we contradict ourselves and raise something unnatural to the position of our philosophy of life.

When men and women affirm this will-to-live

they act naturally and honestly; they devote themselves to life with reverent respect in order to realize its true value; they accept as good practice: to preserve life, to promote life, and to raise life to its highest possible ethical level. This basic reverence for life and the ethic of this attitude has everything that can be described as love, devotion and sympathy whether in joy, suffering or work. We are truly ethical when the lives of our fellow men and women are as sacred to us as our own, and when we devote ourselves to those who need help. Happiness is an aim in life toward which all strive, wrote Aristotle. Happiness for each is found through the best possible performance of the functions for which we are adapted and for this a body in good health is significant.

The goal of the practice of medicine in all of its branches is abundant health for the community as well as for the individual. Medicine seeks to achieve this purpose by curative and preventive measures. The physician relies upon his skill and experience in diagnosis and treatment when a patient presents himself with an illness. Preventive medicine, in contrast, by sanitary control destroys the avenues through which disease attacks, or by immunization renders immune those who are susceptible. The scourge of yellow fever thwarted the construction of the Panama Canal until the mosquito was proved to be the vector of the disease and measures to control mosquito life in the Canal Zone were devised. Typhoid fever, rampant among troops of the Spanish-American war, now is practically eliminated by vaccine immunization and sanitation. Pasteurization of milk eliminates the spread of bovine tuberculosis and septic sore throat; chlorination of drinking water controls the spread of intestinal infections. Therapy for all forms of human illness can be curative or only paliative; sanitation and immunization prevent disease. Preventive medicine therefore is more effective and more practical.

Emotional illness is specifically individual. It is like an endemic rather than an epidemic disease and arises insidiously in the complex and varied conditions of our emotional lives. The solution of some of these health problems requires the help of an understanding friend or of a professional advisor. Such aids, however, as well as the most drastic forms of therapy, are called upon after the disturbance is already rooted. Does a rational system of living contain technics of prevention or of immunization by which we may acquire an equanimity that will shield us when bitter experiences strike at the heart of our emotional life? The principles suggested by Doctor Cabot, and implied by many other therapists, namely, work, play, love and worship can serve a useful purpose to this end.

An inspired love for his or her career, discipline, or profession is a strengthening characteristic in any person's life. We know of physicians, and of those in other activities, who have carried on their life work far beyond the "three score years and ten" and who, by their personality, reflect great vitality and zest for living. Hours, days and years spent under the impact of such a stimulus simply vanish into space. Satisfaction in service rendered is the rich reward. The choice of such a life project can be made with great clarity, almost as though a specific command or a divine call to service had been received.

The Chicago Daily News, Saturday February 28, 1953 published under the caption "My Greatest Spiritual Experience" the following story.

"A young man and his mother stood on a busy street corner, just finished with shopping in preparation for the son's second year at college. He had spent his freshman year at Northwestern University, getting adjusted to a large school and testing his ability to support himself at odd jobs. He was shy and not too sure of this venture, but he had found, that with concentration, he could work his way through school. The urge to obtain further education stemmed from his wish to fit himself for some form of social service. But during that first test year at school, no specific field of work for fulfilling his purpose had made its appeal.

As the two stood there, the young man's mind was occupied with his return to school, and he was troubled by the vagueness of his objective which left him without a stimulating incentive for his work. Suddenly an idea flashed through his mind, and out of the blue he said, "Mother, do you think that I could be a doctor?" After a moment's stillness, the mother spoke: "Yes, I think you can, if you have the training."

That short conversation initiated a supreme emotional experience in the young man. The idea of being a physician grew in his mind

with such stimulating clarity that he lay sleepless on his bed far into the early morning hours, thrilled with excitement and convinced that the real purpose of his life had been revealed to him.

The impact of this revelation of a life purpose carried the young man through 10 years of training in three universities and an excellent medical school, and to the completion of his internship under an outstanding clinician. Years filled with an active practice in his specialty have not dimmed the remembrance of that day. As a physician he has observed sickness and the attendant emotional reactions in others, and several times himself has been a patient, once with a supreme test of his personal qualities. These experiences, however, do not rank with the one spiritual experience when his life's purpose was revealed to him."

Happy, as well as extremely fortunate, are you to have such an experience. It directs your thinking, broadens your perspective, and concentrates your efforts upon an objective against which deterrants of all kinds melt away or become impotent. Let no one think that personal status is a barrier; the most lowly, inspired to a lofty purpose becomes great in true personal values when the impact bears fruit. The necessary ingredients to accomplish this are a zeal for work — work ad infinitum — and direction of purpose. These with judgment assure success.

A contributor to a popular magazine wrote an article several years ago in which he differentiated the elements of a person's education from those of a person's character. Courses in various fields, even accumulated to a large total and commencement degrees, were mentioned as measures of an education. Character, however, the writer regarded as something apart. He finally defined it as that distinctive trait of an individual which continually strives to improve the quality of whatever he does. Accumulated experiences in meeting the demands of your work-load, increase efficiency and confidence in your ability. Seeking, "ye shall know the truth and the truth shall make you free."

Emotional stress seems not to shake the idealism and the finer qualities of a life dominated by a great zeal in purpose. Such a person can and does have emotional reactions, but the deep interest or love of his work, help him to ride out the emotional storms. When in such an emotional tempest you resort to self pity; become resentful, bitter or even have feelings of revenge, remember that these corrode only your soul and do nothing against the object of your reactions. "Still in thy right hand carry gentle peace — let all the ends thou aim'st at be thy country's, thy God's and truth's" was Cardinal Wolsey's advice to Cromwell.

Play can be purposeful as well as relaxing. In a rigid work schedule that few would attempt, Douglas Southall Freeman, the editor, the historian and the eminent biographer of Robert E. Lee and of George Washington, arranged for a lesson in music twice a week. Although he sometimes failed to take an hour of exercise daily in his garden, he derived great satisfaction and inspiration from recorded music even during his work. A professor of pathology himself built a stone wall in his garden and reported, as a by-product of construction, that he had settled many vexing problems besides absorbing a new sense of being from the out-of-doors exercise. A visit to the canyons can be an inspiring experience. At Zion, you gaze upon the solemn beauty of the massive rock formations; at Grand canyon, you are overpowered by its awesome grandeur; and at Bryce, you see, through a stimulated imagination, myriads of forms grouped in artistic pagentry. Or, under the clear canopy of the sky at night, share if you will with Longfellow its beauty, "silently one by one in the infinite meadows of heaven blossom the lovely stars, the forget-me-nots of the angels."

Community and political interests can yield much satisfaction in life. Learned Hand, one of America's most respected jurists, advises that an education for political wisdom must have a large content of the "humanities." By humanities, he means history, but close beside are letters, poetry, philosophy, the plastic arts and music. Differences of opinion frequently arise in various group discussions, and projects of value fail unless some compromise is reached. Hand says that he who would find the substitute in these circumstances needs an endowment rich in experiences which make the heart generous, and provide his mind with an understanding of the hearts of others. Benjamin Franklin's letter written the day before he signed the Constitution of the United States mentioned how an assembly of men, gathered for the advantage

of their joint wisdom inevitably assembled all of their prejudices, their passions, their errors of opinion, their local interests and their selfish views. Yet, Franklin consented to this Constitution because he expected no better and was not sure that it was not the best. Interests in community affairs can be purposeful, if occasionally also trying. Finally, Hand bids us listen to ancient words telling of the excellence of wisdom and summarized in this brief sentence "for she knoweth all things and hath understanding thereof; and in my doings she shall guide me in the way of soberness, and she will guard me in her glory."

The disciplines of work, play and love, balanced and purposefully planned develop strength of character, an asset in maintaining emotional balance or an equanimitas which Sir William Osler, the great physician and teacher, advised his students to acquire.

Physicians, their patients and potential patients are basically human beings. A doctor, because of the nature of his profession, occupies the command position in his professional-patient relations. This may develop an "authority" complex. Sir Thomas Browne in his Religio Medici advised, "Where we desire to be informed, 'tis good to contest with men above ourselves; but to confirm and establish our opinions, 'tis best to argue with judgments below our own, that the frequent spoils and Victories over their reasons may settle in ourselves an esteem and confirmed opinion of our own."

But doctors also become patients and their reaction to such an experience is revealing. Having been in both positions, several times a patient, I cannot be accused of being partisan, or to have a biased opinion. So, when my colleague describes an experience he had as a patient which disclosed conditions that he had not considered possible, I remark only "from now on you will be a better doctor; better in understanding the viewpoint of a patient, especially of how you treat him personally; and what you do or prescribe for the treatment of his disorder." The education of a physician is a continuous process.

We arrive now at "the challenge." The confusing and seemingly explosive unrest which at present grips the world, extends into the social the economic affairs of everyone. The individual poses the question whether a struggle in such an environment is more satisfying than a withdrawal. The one course meets a challenge, the other is an evasion. Edgar A. Mowrer contrasts the two possibilities and stated that no personal adventure can be more fascinating than a supreme adventure of the human race. It is the kind of a voyage, he says, on which today's Americans can embark and where they can find a real sense of well being. The West for the first time in 400 years faces a serious challenge of its leadership. Americans are confronted both with danger and with an unequalled opportunity. Ahead lies the great assignment of preserving the best of the past and of shaping a richer future. We hear the remark that we are at the crossroads with the implied meaning that the choice determines life or death. But really, crossroads are good for us, and are opportunities for decisions to either improve or to deteriorate. There is no static position. The sciences in which medicine is an important segment, have expanded brilliantly in the last two decades, and show no limits of growth. All things point to new frontiers of continuous creation that remain to be explored and developed. Who then would choose complacency over aggressive analysis of our social and economic problems? Mowrer also stated that stagnation can be a greater human enemy than convulsion. Toynbee expressed the opinion that progress in any civilization comes from the creative leadership of an indiivdual or a minority group, which rouses a section of humanity to some hitherto unprecedented effort. No one knows the full limit of his potential capacity under stress. The discipline of challenges met and resolved develops a larger capacity for meeting others.

The unrest in the lives of the Americans, exclusive of those for which they themselves are responsible, stems not from internal dissension but rather is a reflection of at least two complex interwoven processes operating simultaneously; 1) the great West-East struggle for power and 2) the struggle of Asian people for national independence and for economic and political progress. From all of this arises the challenge of Asia to America. Soviet diplomacy seeks to drive a wedge between the peoples of Asia and the United States. The purposes, policies and the actions of the United States are misunderstood in Asia and Europe and are skillfully distorted there by Russian propaganda and native com-

munists. The basic causal factors in the vast Asian upheaval are; 1) a struggle of the Asians for freedom of living through self government, 2) the great food shortage — hunger — which the Asians ascribe to the feudal economic system that has made them improverished land slaves instead of owners of the land they till, and 3) a struggle for self respect, spurred by an urge to prove this to others as well as to themselves, rather than the servitude in which they have been held.

The results of these conditions coupled with the unrest in the war ravaged countries of Europe where other similar and dissimilar situations exist, affect our own affairs of living. Since many of these problems obviously are in the realms of health and nutrition, they are basic in the struggle for maintaining life and reach into the medical practices. We have similar problems to be sure, but they are much smaller in contrast with those of the Asians., The Challenge is then to those who have, in contrast to those who have not, and it is obvious that the adjustments will come through the principle of giving — giving of whatever the health or economic commodity may be, and in whatever form may be the tokens of exchange.

Bravery is courage in action said General Omar N. Bradley. It is that quality which enables a person to face a challenge with decision and purpose, whether that challenge be imminent physical danger, the defense of a moral principle, or a pioneering effort in new fields of progress. In each case, the brave person stakes everything with conviction and fortitude. Foolhardy heroics are not bravery. The truly brave are quiet, calm and self-possessed, make no display of audacity, hold in check their emotions while calculating the outcome of a drastic move. Bravery is courage in action and produces the deed that sets the hero above the coward.

We may argue among ourselves about principles and how social adjustments and improvements should be made but we will face the challenges, and will rise to better levels. New frontiers for this remain.

When by my solitary hearth I sit,
And hateful thoughts enwrap my soul with gloom,
When no fair dreams across my mind's eye flit,
And the bare heath of life presents no bloom,
Sweet hope, ethereal balm upon me shed,
And waft thy silver pinions o'er my head.

John Keats

‹ ‹ ‹ › › ›

Why de-emphasize syphilis?

Unfortunately, as the first skirmishes against syphilis appeared won, a sense of false security developed, even among phyicians; and in 1950 Congress began drastic cuts in the funds necessary to sustain the essential activities of the program. This dubious economy move also was promoted by the misconception that penicillin with its excellent treatment effects would somehow possess equal case-finding magic. Epidemiologists are aware that the propagation of venereal diseases is sustained by the reservoir of infectious undiagnosed cases. Treatment is essential to the diagnosed case but cannot affect the undiagnosed reservoir or rate of spread therefrom. As a result of premature de-emphasis, 24 state health departments now consider their venereal disease funds insufficient to permit effective case finding and to insure a continual fall in rates. Supporting their belief is that fact that during 1954, 20 states experienced a rise in reported syphilis rates and 36 a rise in gonorrhea. *A. L. Van Duser, M.D. Venereal Disease is Still with us. Wisconsin M.J. May* 1955.

CORRESPONDENCE

Psychiatric lecture series for all physicians

The sixth annual North Shore Health Resort lecture series for 1955-1956 has been announced by Samuel Liebman, M.D., Medical Director. Psychiatric Problems in Medical Practice is the theme.

Open to all physicians, the lectures are given at the hospital, 225 Sheridan Road, Winnetka, at 8:00 p.m. As in the past, the American Academy of General Practice will give credit to its members for attendance. The complete program follows—

Oct. 5, 1955. The Management of Psychiatric Emergencies. Karl M. Bowman, M.D., Med. Supt., The Langley Porter Clinic; Prof. of Psychiatry, U. of Calif. Med. School, San Francisco; Past President, Amer. Psych. Assn.

Nov. 2, 1955. The Use and Abuse of Sedatives and Stimulants. Francis J. Gerty, M.D., Prof. & Head, Dept. of Psychiatry, Dir. Psych. Div. Neuropsych. Inst. U. of Ill. Col. of Med.; Sr. Attndg. Psych. St. Luke's Hosp.; Chrm. Deans' Subcom. on Psych., V.A.H., Hines, Ill.

Dec. 7, 1955. The Management of the Anxious Patient. Lewis L. Robbins, M.D., Director, Dept. of Adult Psychiatry, The Menninger Foundation, Topeka, Kansas.

Jan. 4, 1956. The Management of the Depressed Patient. Franklin G. Ebaugh, M.D., Clin. Prof. of Psychiatry, U. of Colorado School of Medicine; Regional V.A. Cons.; Member Res. Review Com. of A.M.A.; Editorial Board of many professional journals, Denver.

Feb. 1, 1956. The Management of Emotional Reactions in the Male Involutional Period. Otto Billig, M.D., Assoc. Prof. of Psychiatry, Vanderbilt U. School of Medicine; Psych.-in-Chief, O.P.D. Vanderbilt University Hospital, Nashville.

Mar. 7, 1956. The Management of the Multiple Complainer. George C. Ham, M.D., Prof. and Chrm. Department of Psychiatry, U. of North Carolina, School of Medicine; Chief of Service, North Carolina Memorial Hospital, Chapel Hill, North Carolina.

Apr. 4, 1956. The Management of Overeating, Overdrinking and Oversmoking. Leo H. Bartemeier, M.D., Med. Dir., Seton Psychiatric Inst., Baltimore; Teaching Analyst, Wash Psychoanalytic Inst., Clin. Prof. of Psychiatry, Georgetown U. Medical School, Washington, D.C.

May 2, 1956. The Prevention of Iatrogenic Disorders. Walter C. Alvarez, M.D., Prof. Lecturer in Medicine Emeritus, U. of Ill. Col. of Med., Consultant in Medicine Emeritus, Mayo Clinic; Ed.1in-Chief, Modern Medicine, Geriatrics; Editorial Board of other journals and newspapers.

June 6, 1956. The Utilization of Community Resources in Medical Practice. Marc H. Hollender, M.D., Assoc. Prof. Dept. of Psychiatry, Chief Psych. O.P.D., Neuropsychiatric Inst., U. of Ill. Col. of Med.; Staff Member, Institute for Psychoanalysis, Chicago.

« »

Postgraduate Assembly of the Endocrine Society

"Endocrinology and Metabolism" is the subject for the seventh annual Postgraduate Assembly of the Endocrine Society being held in Indianapolis, Sept. 26-Oct. 1, with the cooperation of the Indiana University School of Medicine.

Continuation study facilities of the Indiana University Medical Center will be utilized for the sessions at which 21 leading clinicians and investigators will be heard.

Information regarding the program, registration, etc., is available by addressing: Postgraduate Office, Indiana University School of Medicine, 1100 West Michigan, Indianapolis 7, Indiana.

« »

He was there

Dr. Andy Hall
Chairman of the 50 Year Club
1802 Broadway Street,
Mount Vernon, Illinois

Dear Dr. Hall:

I consider it a rare privilege to have had the honor to be present at the banquet of the 50 Year Club. I did not feel like a "Stranger in Paradise" among them, but what it represented is strange to our own profession. As I looked around me, I observed Man, representing kindness, dignity, simplicity, and most of all, "missionaries that guide the health and lives of the human race".

I do not know of any other profession that

could offer the same and to you, Dr. Hall, I have no words in my vocabulary to express my admiration for your mental alertness, your wisdom, and your ambition. I am certain that all those that listened to you were convinced that they had justly earned their honor.

Sincerely yours,
John Peters, M.D.

P. S. I was the guest of Dr. W. C. Alvarez, and in six more years I hope to join all of you.

‹ ›

Clinics for crippled children listed for September

Twenty five clinics for Illinois' physically handicapped children have been scheduled for September by the University of Illinois Division of Services for Crippled Children. The Division will count 19 general clinics providing diagnostic orthopedic, pediatric, speech, and hearing examinations along with medical social and nursing service. There will be 4 special clinics for children with rheumatic fever and 2 for cerebral palsied children.

Clinics are held by the Division in cooperation with local medical and health organizations, both public and private. Clinicians are selected among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or may want to receive consultative services.

The September clinics are:

September 1 — Sterling, Field House
September 6 — Alton, (Cerebral Palsy all day, General Pediatric a.m. Rheumatic Fever p.m.,) Alton Memorial Hospital
September 7 — Rock Island (Cerebral Palsy), Foss Home, 3808 — 8th Ave.
September 7 — Hinsdale, Hinsdale Sanitarium
September 8 — Springfield, St. John's Hospital
September 8 — Elmhurst (Rheumatic Fever), Memorial Hospital of DuPage County
September 8 — Clinton, Christian Church
September 9 — Chicago Heights (Rheumatic Fever), St. James Hospital
September 13 — Peoria, Children's Hospital
September 13 — East St. Louis, St. Mary's Hospital
September 14 — Joliet, Will County T.B. Sanitarium
September 15 — Anna, New City Hospital
September 15 — Rosiclare, Y.M.C.A., Building
September 16 — Evanston, St. Francis Hospital
September 20 — Centralia, Recreation Center
September 21 — Evergreen Park, Little Company of Mary Hospital
September 21 — Jacksonville, Our Savior's Hospital
September 22 — Rockford, St. Anthony's Hospital
September 22 — Bloomington, St. Joseph's Hospital
September 22 — Chester, Lutheran School
September 23 — Chicago Heights (Rheumatic Fever), St. James Hospital
September 27 — Peoria, Children's Hospital
September 27 — Effingham (Rheumatic Fever), St. Anthony's Hospital
September 28 — Springfield (Cerebral Palsy), Memorial Hospital
September 28 — Aurora, Copley Memorial Hospital

‹ ›

The American Congress of Physical Medicine and Rehabilitation

The 33rd annual scientific and clinical session of the American Congress of Physical Medicine and Rehabilitation will be held August 28-September 2, 1955 inclusive, at the Hotel Statler, Detroit.

Scientific and clinical sessions will be given August 29 through September 2. All sessions will be open to members of the medical profession in good standing with the American Medical Association.

In addition to the scientific sessions, annual instruction seminars will be held. These lectures will be open to physicians as well as to therapists who are registered with the American Registry of Physical Therapists or the American Occupational Therapy Association.

Full information may be obtained by writing to the executive secretary, Dorothea C. Augustin, American Congress of Physical Medicine and Rehabilitation, 30 North Michigan Ave., Chicago 2, Ill.

New appointments at Northwestern University Medical School

Five members of the Northwestern University medical school faculty have been promoted to the rank of full professor, it was announced today. One promotion in the dental school was also announced.

Promotions in the medical school include Dr. William Baker, 5830 Stony Island ave., Chicago, professor of urology; Dr. John Dorsey, 2440 N. Lakeview, Chicago, professor of surgery; Dr. Benjamin Kagan, 1332 E. Madison ave., Chicago, professor of pediatrics; Dr. George K. Yacorzynski, 2734 Sheridan rd., Evanston, professor of neurology and psychiatry; and Dr. Samuel J. Zakon, 5840 W. Adams st., Chicago, professor of dermatology.

Dr. Joseph C. Calandra, 4918 Rice St., Chicago, was named professor of pathology in the school of dentistry.

Appointments are effective Sept. 1, 1955.

‹ ›

Instruction in occupational skin problems

The Institute of Industrial Health of the University of Cincinnati announces that the course of instruction in Occupational Skin Problems will be given October 10-14, 1955. It will be presented by the Department of Preventive Medicine and Industrial Health, University of Cincinnati, in collaboration with the Occupational Health Program of the United States Public Health Service, and the Department of Dermatology and Syphilology of the University of Cincinnati. The objective of this course is to give physicians a greater understanding of cutaneous problems of occupational origin.

The program will be divided into three daily sessions, consisting of morning lectures and clinical demonstrations, afternoon field instruction in industrial plants, and evening panel discussions. The didactic presentations will include a review of the anatomy, physiology and chemistry of the skin. Detailed consideration will be given to the etiology, diagnostic evaluation and treatment of occupational dermatoses, as well as specific measures for prevention and control of these problems. Current concepts regarding cutaneous cancer, allergic reactions and medicolegal problems will be discussed.

Physicians interested in attending the course should write for an application blank to Secretary, Institute of Industrial Health, Kettering Laboratory, Eden and Bethesda Aves., Cincinnati 19, Ohio. Early application is advised since attendance will be limited.

‹ ›

Officers of Illinois Medical Service Blue-Shield Plan

Percy E. Hopkins, M. D., was elected president of the Blue Shield Medical-Surgical Plan of Illinois Medical Service, and Leo P. A. Sweeney, M. D., was named secretary at the annual election of officers at Plan headquarters, 425 North Michigan Avenue, according to an announcement made today by R. T. Evans, executive director of the Plan.

Re-elected to their respective posts were George E. Coleman, M. D., vice president, and Arkell M. Vaughn, M. D., treasurer.

Dr. Hopkins is a past president of the Illinois State Medical Society and resides at 8411 South Paulina St., Chicago.

This Blue Shield Plan, organized in 1947 by physicians who saw the need for such a program, enrolled 19,674 members in its first year of operation. Today, the Plan has 1,190,670 members, Evans reported. He also pointed to the fact that payments totaling $7,462,589 in benefits were paid last year by Blue Shield.

‹ ›

Course in postgraduate gastroenterology

The American College of Gastroenterology announces that its Annual Course in Postgraduate Gastroenterology will be given at The Shoreland in Chicago, Ill., on October 27-28-29, 1955.

The course again will be under the co-chairmanship of Dr. Owen H. Wangensteen, Professor of Surgery of the University of Minnesota Medical School, who will serve as surgical co-ordinator and Dr. I. Snapper, Director of Medical Education, Beth-el Hospital, Brooklyn, N. Y., who will serve as medical co-ordinator. Drs. Wangensteen and Snapper will be assisted by a distinguished faculty selected from the medical schools.

The subject matter, from a medical as well as a surgical view-point, will cover advances in diagnosis and treatment of gastrointestinal

diseases and a comprehensive discussion of diseases of the mouth, esophagus, stomach, pancreas, spleen, liver, gallbladder, colon, rectum, with special studies of radiology and gastroscopy.

For further information and enrollment write to the American College of Gastroenterology, Department P.G., 33 West 60th Street, New York 23, N. Y.

‹ ›

Mississippi Valley Medical Society meeting

The 20th Annual Meeting of the Mississippi Valley Medical Society will be held at the Hotel Jefferson, St. Louis, Sept. 28, 29, 30. Over 50 clinical teachers from the leading medical schools will conduct Midwest's Greatest Intensive Postgraduate Medical Assembly" which will present the latest advances in medicine. The program will include 6 panel discussions: Hypertension and Obstetrics (Sept. 28), Geriatrics and Psychosomatic Medicine (Sept. 29), Biliary Tract Diseases and G-I Bleeding (Sept. 30). The program will be conducted by leading clinical teachers from the medical schools in Columbia and St. Louis, Chicago, and Iowa City plus a number of clinicians from more distant states including Dr. Elmer Hess, President of the American Medical Association; Drs. Edward N. Cook, Richard M. Schick, Waltman Walters, and Eric E. Wollaeger, of the Mayo Clinic; Dr. Arthur C. Corcoran of the Cleveland Clinic; Dr. A. R. Curreri of the University of Wisconsin; Dr. Robert P. Culter, of the U.S. P.H.S. Narcotic Hospital, Lexington, Ky; Dr. George A. Hellmuth of Marquette University, Milwaukee; Dr. Edward Henderson, Montclair, N.J., Editor, Journal of the American Geratrics Society; Dr. Wm. C. Menninger, Topeka, Kansas, of the Menninger School of Psychiatry; Dr. Wm. L. Watson, New York University — Bellevue Medical Center, New York; Dr. Arnold S. Jackson, President of the International College of Surgeons; and Dr. Wm. L. Valk of the University of Kansas.

All members of the AMA are cordially invited and urged to attend. (Non-members pay a $5.00 registration fee). There will be a large exhibit hall of technical and scientific exhibits. The 12th annual meeting of the American Medical Writer's Association, "America's only Association Devoted to Improvement of the Written Word of Medicine" will also meet at the Hotel Jefferson, Sept. 30, Oct. 1. Further details of both meetings may be obtained from Harold Swanberg, M.D., Secretary, 209-224 W.C.U. Building, Quincy, Ill.

‹ ›

Postgraduate courses on diseases of the chest

The Council on Postgraduate Medical Education of the American College of Chest Physicians, in cooperation with the respective state chapters of the College, as well as the staffs and faculties of the local hospitals and medical schools of Chicago and New York City will sponsor the following postgraduate courses on diseases of the chest this fall:

10th Annual Postgraduate Course, Hotel Knickerbocker,
Chicago, Illinois, October 3-7, 1955

8th Annual Postgraduate Course, Park-Sheraton Hotel,
New York City, November 14-18, 1955

The postgraduate courses endeavor to bring physicians up to date on recent advances in the diagnosis and treatment of heart and lung disease. Tuition is $75 for each course which includes round table luncheons.

Further information may be secured by writing to the Executive Director, American College of Chest Physicians, 112 East Chestnut St., Chicago 11, Ill.

‹ ›

Hektoen institute awards

The Hektoen Institute for Medical Research of Cook County Hospital wishes to announce the following: Silver medal award, AMA, to Drs. B. M. Gasul, E. H. Fell, H. G. Bucheleres, C. J. Marienfeld, Gershon Hait, R. F. Dillon, P. B. Szanto and Maurice Lev for exhibit on angiocardiography in normal and abnormal hearts; a $10,000 grant from the Damon Runyon Memorial Fund for Cancer Research for studies in leukemia; a $10,000 grant from the Dr. Leonard H. and Louis Weissman Medical Research Foundation for studies in radioactive isotopes; and a $15,000 grant from the Olivia Sue Dvore Foundation for leukemia research.

NEWS of the STATE



COOK

New Officers of Chicago Medical Society.—Dr. Maurice M. Hoeltgen was installed as president of the Chicago Medical Society at ceremonies in the Society's Headquarters, 86 East Randolph Street, June 29. He succeeds Dr. Frank H. Fowler. Other officers are Doctors Norris J. Heckel, who was re-elected secretary, and Dr. Karl A. Meyer, medical superintendent of Cook County institutions, who was chosen president elect. Installed as councilors-at-large were Doctors Harry Oberhelman, Aux Plaines Branch; Leo P. A. Sweeney, Calumet Branch; C. W. Stigman, Irving Park Branch; Edward Compere, North Suburban Branch, and G. Henry Mundt, Englewood Branch. The occasion was also marked by a special tribute to Mrs. Esther A. Fraser, who is entering upon her forty-second year as the assistant secretary of the Society.

County Maternal Welfare Committee Formed.—Dr. Fiske Jones, Oak Park, was recently elected chairman of the newly-organized Suburban Cook County Maternal Welfare Committee. Other officers are Drs. Paul E. Lawler, Chicago, vice-chairman, and Dr. William M. Hanrahan, Chicago, secretary-treasurer. The new County Welfare Committee was organized through the efforts of Dr. Frederick H. Falls and the directors of the obstetric department of Suburban Cook County Hospital.

Personal.—Dr. Loyal Davis, Grunow professor of surgery and chairman of the department, Northwestern University Medical School, has been awarded an honorary fellowship in the Royal College of Surgeons, newspaper report. Dr. Davis was to receive the honor at a special convocation in London, July 28.—Dr. James K. Stack, associate professor of orthopedic surgery at Northwestern University Medical School, has been installed as president of the medical staff of Passavant Memorial Hospital, succeeding Dr. Howard L. Alt. Dr. Howard A. Lindberg, assistant professor of medicine, was chosen president-elect to take office next year. Dr. John Bell, associate in surgery at Northwestern, was elected secretary of the staff.

Fifty Years of Marriage.—Drs. and Mrs. A. E. Jourdan observed their golden wedding anniversary, July 26. Their only daughter and son-in-law, Mr. and Mrs. J. H. Schoenheit, held a dinner and reception in their honor for relatives and friends. Dr. Jourdan, who has been practicing for forty-eight years and who still maintains a limited private practice, is a member of the staff of Martha Washington Hospital.

Chicago Medical Society Post-Graduate Courses.—The Chicago Medical Society will sponsor two post-graduate courses at the Knickerbocker Hotel, 163 East Walton Street, Chicago. One, October 17-21, 1955, will deal with "Basic Principles and Recent Developments in Pediatrics." The other, October 24-28, will cover "Basic Principles and Recent Developments in Obstetrics and Gynecology." The registration fee is $75.

Society News.—Dr. Richard A. Perritt, senior attending staff, department of ophthalmology, Chicago, Wesley Memorial Hospital, addressed the International College of Surgeons in Geneva, Switzerland, May 23, on "The Ridley Intra-Ocular Acrylic Lens Operation—Comments and Modifications."—Dr. John B. Hall, director of the Cook County Department of Public Health, was recently elected president of the Illinois Association of Medical Health Officers. Other officers include Drs. Herbert S. Ratner, health officer of Oak Park, president-elect, and Dr. Nicholas R. Frankovelgia, health officer of Berwyn, secretary-treasurer.

University News.—The Asthmatic Children's Aid has given $4,500 to the Chicago Medical School toward a research project on "The Role of C-Reactive Protein in Allergic Inflammation." The work is being carried on under the direction of Drs. A. L. Aaronson, assistant professor of medicine at the Chicago Medical School and director of the Allergy Clinic at Mount Sinai Hospital, and Morris A. Kap-

lan, assistant professor of medicine and director of the Allergy Research Unit at the Chicago Medical School.—The Dr. M. L. Parker Award, presented on recommendation of the Chicago Medical School faculty to one of its members for meritorious, scientific research, was awarded to Dr. Phillippe Shubik, Coordinator of Oncology in the department of surgery.

Specialty Society Election.—Dr. Roy R. Grinker was recently elected president of the Illinois Psychiatric Society. Other officers are Dr. George R. Perkins, vice-president, Dr. Samuel Burack, 737 N. Michigan, secretary-treasurer, and Drs. Percival Bailey and Charles B. Congdon, councilors.

Plan Seventy Bed Expansion at Weiss Hospital.—The Louis A. Weiss Memorial Hospital, Chicago, will begin a one million dollar expansion program in September. The present plans call for a two-floor addition to the hospital which was opened two years ago with a bed capacity of 110. The new section will include a nursery with twenty-three bassinets and an obstetrical unit with twenty-three beds. The original four-story building had no facilities for maternity cases. Should funds become available during the proposed building program, a seventh and eighth floor will be added, bringing to full capacity the plans for 250 beds, according to the Chicago Tribune.

Memorial Service for Harvey S. Allen.—On July 6 a memorial service for the late Dr. Harvey S. Allen was held at Northwestern University Medical School. Participating were Dr. Richard H. Young, dean of the medical school, and Dr. Sumner L. Koch, professor emeritus of surgery. Both were close friends and colleagues of Dr. Allen who was professor of surgery at Northwestern and a member of the attending staff of Passavant Hospital at the time he died, May 30.

DU PAGE

Coroner Receives Honor.—Dr. Samuel K. Lewis, coroner of DuPage County, recently was named to the American Academy of Forensic Sciences. Dr. Lewis is said to be the only county coroner in the academy in Illinois.

FORD

Dr. Peterson Honored.—Dr. M. D. Peterson, Paxton, was honored recently when a "Dr. Peterson Night" was held. More than 125 persons attended a banquet in appreciation of Dr. Peterson's service to Paxton and Rankin, Illinois. He practiced in Paxton for 38 years and in Rankin, 9 years. The Paxton Chamber of Commerce presented the physician with a plague in commemoration of the event. Dr. Peterson, who is a member of Alpha Omega Alpha, has served as county physician for the past 15 years and city physician for the past 20. Dr. Peterson graduated at the University of Illinois College of Medicine, class of 1906.

WINNEBAGO

Memorial to Dr. Lundholm.—A grandfather's clock has been given to the Winnebago County Medical Society as a memorial to Dr. Joseph S. Lundholm who, at the time of his death, was councilor of the first district. The clock was the gift of Mrs. Lundholm.

Society Collection Bureau Being Formed.—According to the Bulletin of the Winnebago County Medical Society, the groundwork has been laid to start a society collection bureau. It is hoped that when the bureau actually begins functioning, it will extend a great service to physicians as well as be a strong instrument for good public relations.

GENERAL

Health Lectures at the Museum of Science and Industry.—The 1955 Fall Lecture Series at the Museum of Science and Industry, Chicago, will be conducted on Sunday afternoons at 3 p.m., beginning on September 25 and continuing for five Sundays. Dr. Elmer Hess, Erie, Pa., President of the American Medical Association will be the first speaker and will be introduced by Dr. F. Garm Norbury, Jacksonville, Ill., President of the Illinois State Medical Society. The second lecture will note the meeting of the pediatricians in Chicago, with Dr. Willis J. Potts as speaker. He will be introduced by Dr. A. Crawford Bost, San Francisco, President of the American Academy of Pediatrics. Features are being planned for each of the other lectures. The complete list of subjects and speakers follows:

Elmer Hess, M.D., Erie, Pa., September 25, The Patient and the Doctor.

Willis J. Potts, M.D., Chicago, Surgeon-in-Chief, Children's Memorial Hospital, October 2, The Heart of a Child.

Philip Thorek, M.D., Chicago, associate professor of surgery, University of Illinois College of Medicine, October 9, Food for Thought about Health.

J.W.J. Carpender, M.D., Chicago, professor of radiology, The University of Chicago, October 16, X-Rays and Radioactive Substances.

Morris Fishbein, M.D., Chicago, clinical assistant professor of medicine, University of Illinois College of Medicine (Rush), October 23, Live Longer and Like It.

Needs of Physically Handicapped Children.—The Chicago Board of Education recently released a booklet on the needs of physically handcapped children together with a report of the survey of pupils in Chicago's special schools as of April 1, 1954. The booklet, which may be had on request from the Board of Education, is a comprehensive presentation on the status of these handicapped children. According to the summary, among the children receiving the care in the four special elementary schools and one special high school for

children so physically handicapped that they cannot attend classes in regular schools, there is great diversity in the physical handicaps of the pupils: 126 different diagnoses are represented. Cerebral palsy accounts for the largest group: it itself produces a wide variety of handicaps. Poliomyelitis, cardiac conditions, congenital deformities, muscular dystrophy, and tubercular joints follow in order of numerical importance.

Only 25 children in the 5 schools are there because of accidental injuries. Many of these pupils have more than one physical handicap: a weak heart with spina bifida; convulsions with cerebral palsy; and a multitude of other combinations. Sixty-one have a hearing loss and 93 a visual defect added to the major physical handicap. Mental handicap is several times more prevalent in the physically handicapped group than in a normal group.

Who should attend a special school, for how long, and for what specific reasons, the report asks. The survey suggests that there is no simple answer. The needs of these children are varied and complex. Some are enrolled in order that they may have bus transportation and a school facility that presents no stairs or other obstacles to mobility. Some are enrolled primarily for protection: the hemophiliac who bleeds at the slightest touch, the severe cardiac, the tiny dwarf who would be lost if not trampled in a normal group, a few terrific facial anomalies who might be subjected to severe trauma in a group unaccustomed to the unusual. Some could not attend any school unless there were attendants available: the paralytics without bladder control, the cerebral palsy who cannot feed himself, the wheelchair child who cannot propel himself. Some are being fitted with a prosthesis and will be returned to the regular school when, with the help of the physical therapist, they have mastered the difficult art of using an artificial arm or leg. Some because of over-protection at home and in the community have never learned to exert themselves to achieve the degree of independence of which they are physically capable.

When the special school has restored the confidence of child and parent by helping the child develop physical and psychological independence. According to the report, the survey indicates how complex the decisions are, how many factors must be taken into account. It strengthened the conviction that there must be close cooperation, mutual understanding, and teamwork between all concerned: the parent, the teacher, the physician, the special school, the regular school, the therapist, the social agencies, and any others working with a child and his family.

"Your Doctor Speaks" over FM Station WFJL.—The following physicians have recently participated in the series "Your Doctor Speaks" over FM Station WFJL under the auspices of the **Educational Committee** of the Illinois State Medical Society.

Harold A. Grimm, clinical assistant professor of pathology, University of Illinois College of Medicine, Blood Collection and Transfusion Therapy.

Charles S. Gilbert, clinical assistant in medicine, Stritch School of Medicine of Loyola University, Diet and Disease.

Louise Tavs, clinical assistant professor of dermatology, University of Illinois College of Medicine, Care of the Skin.

H. Paul Carstens, clinical associate attending physician in medicine, Cook County Hospital, Hypertension.

Frank M. Quinn, member of the staff of St. Francis Hospital, Evanston, What Preventive Medicine Holds for You.

"All About Baby" on WGN-TV, Channel 9.—The following physicians have appeared on the telecast "All About Baby" on WGN-TV, Channel 9, under the auspices of the **Educational Committee** of the **Illinois State Medical Soceity.** The telecast, a Jules Power Production, features Lorraine Douglas, R.N.

Edmond R. Hess, clinical assistant in pediatrics, Northwestern University Medical School, June 29, on Importance of Nutrition and a Well-Balanced Diet.

Benjamin Levin, associate professor of pediatrics, Chicago Medical School, July 6, on Tuberculosis.

George Eisenberg, attending physician, Chapin Hall, July 13, on Vitamins and Deficiency Diseases.

William R. Best, assistant professor of medicine, University of Illinois College of Medicine, July 20, on Anemia, Leukemia and Hemophilia.

Henry Fineberg, Director, Child Guidance Clinic, Children's Memorial Hospital, July 27, on Understanding Your Child's Nervous System.

Matthew M. Steiner, associate attending pediatrician, Children's Memorial Hospital, August 3, on Diabetes in Children.

Lectures Arranged Through the Scientific Service Committee of the **Illinois State Medical Society:**

Frederick Steigmann, Chicago, La Salle County Medical Society at the Kaskaskia Hotel, La Salle, September 8, on Diagnostic Considerations of Jaundice.

William H. Requarth, Decatur, Henry County Medical Society at the Kewanee Hotel, Kewanee, September 14 on Injuries of the Hand.

Max Samter, Chicago, Marion County Medical Society at the Hotel Langenfeld, Centralia, September 15, on Drug Reactions.

Ford K. Hick, Chicago, Kankakee County Medical Society at the Kankakee Hotel, Kankakee, September 20 on Office Management of Diabetes.

Steven O. Schwartz, Chicago, Iroquois County Medical Society at the Christian Church, Watseka, September 20, on Treatment of Lymphomas and Leukemias.

DEATHS

Correction

The death of Leo E. Schneider*, M.D., Oregon, member of the Ogle County Medical Society, was erroneously reported in **The Illinois Medical Journal**, June 1955. We regret the error. Dr. Schneider, who is alive and well, is now living in Milwaukee.

Ottokar Beschloss, Taylorville, who graduated at Friedrich-Welhelms-Universität Medizinische Fakultät, Berlin, Pressia, Germany, in 1923, died in Springfield, April 30, aged 55, of coronary occlusion.

Eugene E. Birmingham*, Chicago, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois in 1907, died July 3, aged 70. He was a member of the American Academy of Ophthalmology and Otolaryngology.

Cornelius R. Cain*, Chicago, who graduated at the University of Illinois College of Medicine in 1928, died October 1, aged 57.

Parley Carper Casto*, St. Joseph, who graduated at Baltimore Medical College in 1900, died May 13, aged 81, of cerebrovascular accident and chronic hypertensive arteriosclerosis.

Albert John Chesrow*, retired, who graduated at Loyola University School of Medicine in 1919, died June 14, aged 58.

John Harris Dent, Jr., Chicago, who graduated at Chicago Medical School in 1928, died April 25, aged 56.

William P. Donovan, Rantoul, who graduated at St. Louis College of Physicians and Surgeons in 1903, died May 6, aged 74.

Victor S. Frankenstein*, Chicago, who graduated at Northwestern University Medical School in 1895, died June 15, aged 85.

Arthur Gaebler*, retired, Chicago, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1895, died May 15, aged 88.

Manuel Goldfine*, Chicago, who graduated at the University of Illinois College of Medicine in 1936, died May 7, aged 47, of acute posterior myocardial infarction and arteriosclerotic heart disease.

Frederick E. Hambrecht*, Galesburg, who graduated at the State University of Iowa College of Medicine in 1929, died May 1, aged 51.

Halbert A. Haynes*, formerly of Chicago, who graduated at the University of Louisville School of Medicine in 1898, died in St. Petersburg, Florida, July 7, aged 84.

Gabriel B. Kramer*, formerly of Rockford, who graduated at Baltimore Medical College in 1907, died in Washington, D. C., April 6, 1955, aged 71, of a cerebral hemorrhage. He formerly served as pathologist at Anker Hospital, St. Paul, Minnesota, Youngstown Hospital in Youngstown, Ohio, St. Mary's Hospital, Decatur, and Illinois and Swedish American Hospital in Rockford.

Harry S. Lester*, Streator, who graduated at the State University of Iowa College of Medicine in 1898, died June 19, aged 84. He was a member of the American Academy of Ophthalmology and Otolaryngology.

Louis M. Munson*, Chicago, who graduated at Rush Medical College in 1910, died July 5, aged 70. He was a member of the staff of Alexian Brothers Hospital.

Jerome Francis Poniatowski*, Chicago, who graduated at Loyola University School of Medicine in 1943, died May 20, aged 38, of coronary occlusion.

Walter Winfield Sheerer*, Christopher, who graduated at the Eclectic Medical Institute, Cincinnati, in 1905, died May 2, aged 74.

Kellogg Speed*, Highland Park, who graduated at Rush Medical College in 1904, died July 2, aged 76. He was clinical professor of surgery, emeritus, at the University of Illinois College of Medicine; he had been head surgeon at Presbyterian Hospital, member of the staffs of Highland Park and Lake Forest Hospitals, first president of the American Association for the Surgery of Trauma, and a former president of the Chicago Surgical Society.

John J. Theobald*, Oak Park, who graduated at Rush Medical College in 1920, died July 5, aged 66. He was assistant professor of laryngology at the University of Illinois College of Medicine and a member of the American Academy of Ophthalmology and Otolaryngology.

Clyde L. Vanatta*, Alton, who graduated at Indiana Medical College, School of Medicine of Purdue University, in 1906, died May 15, in North Madison, Indiana, aged 71.

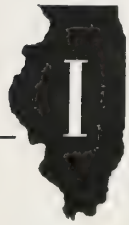
Samuel H. Wiener*, Chicago, who graduated at the Chicago College of Medicine and Surgery in 1913, died May 7, aged 66, of ruptured abdominal aortic aneurysm and arteriosclerosis. He was a member of the staff of the Mother Cabrini Memorial Hospital.

George Kent Worden, Alton, who graduated at Washington University School of Medicine, St. Louis, in 1903, died April 17, aged 78.

---

*Indicates member of the Illinois State Medical Society.

HOUSE OF DELEGATES



The second session of the House of Delegates of the Illinois State Medical Society was held at the Hotel Sherman, Chicago, on Thursday, May 19, 1955. The meeting was called to order by the President, Dr. A. M. Vaughn, at 3:35 P.M.

THE PRESIDENT: The first order of business is the report of the Credentials Committee, Dr. Harlan English, chairman.

DR. HARLAN ENGLISH, Danville: There is a quorum present, 120 delegates, officers and members of the Council having been certified. I move that this number, as certified by the attendance slips checked against the voting list, constitute the voting strength of this meeting. (Motion seconded by Dr. Earl Blair, Chicago, and carried).

THE PRESIDENT: The next order of business is the roll call by the Secretary.

DR. H. M. CAMP, Monmouth: I move that the attendance slips constitute the roll call. (Motion seconded by Dr. E. A. Lukaszewski, Chicago, and carried).

THE PRESIDENT: The next item on the agenda is the reading of the minutes of the previous session.

DR. C. PAUL WHITE, Kewanee: I move that the reading of the minutes be dispensed with. (Motion seconded by Dr. Elmer V. McCarthy, Chicago, and carried).

THE PRESIDENT: At this time we have a guest, Dr. Ruth Church of the State Department of Health, who wishes to make an important announcement regarding the Salk vaccine.

DR. MATHER PFEIFFENBERGER, Alton: I move that Dr. Church be given the privilege of the floor. (Motion seconded by Dr. Elmer V. McCarthy, Chicago, and carried).

DR. RUTH CHURCH: The thing that I want to bring to your attention and hope that you can convey it to your colleagues back home is that the polio situation, nationwide, is going to be very atypical this year because of the introduction of the vaccine program, not only in the state but in the whole United States. We also hope that you will be particularly conscientious about reporting diagnosed polio cases to your health officers and even reporting those that you are suspicious may be polio. There are laboratory tests being set up nationwide, so we can do things to reaffirm suspected polio, particularly in vaccinated children. We would like to have blood samples. We will examine the blood and then in two or three weeks examine another sample, which will help us to evaluate the effectiveness of the vaccine and also will let us know where we stand in connection with polio. I would say only, get in touch with your full time officer and he will have information. If you cannot get in touch with him, get in touch with me at Springfield or with Dr. Howard Shaughnessy here in Chicago. We are anxious to help, and to get all the information we can.

THE PRESIDENT: Thank you Dr. Church. The next order of business is the selection of a meeting place for the 1958 meeting.

THE SECRETARY: We have been selecting the place for the annual meeting three years in advance. It has been set for Chicago for 1956 and 1957. We are to decide for 1958. Since I came to the hotel I received a very cordial invitation from the Chamber of Commerce to meet in Springfield next year, but we are set up in Chicago for next year and the following year. Unfortunately the facilities for a meeting are not available in Springfield or in Peoria.

DR. W. E. KITTLER, Rochelle: I move that the choice of a meeting place for 1958 be left to the decision of the Council. (Motion seconded by Dr. E. E. Davis, Avon, and carried).

THE PRESIDENT: We come to unfinished business. The Secretary says there is none, so we will pass to new business. I would like to introduce Dr. M. R. Saxon of Kendall County. This is the first new county society in 40 years.

DR. SAXON: It was amazing to me to find out with the establishment of our Kendall County Society that we were not the smallest society in the State of Illinois. It may surprise you to know that there are societies in the State that have but few members. We have seven. On behalf of our seven members I wish to say that we are very pleased to become part of this very fine medical group.

THE PRESIDENT: Dr. George C. Turner has a report from the Committee on Tuberculosis Control.

DR. GEORGE C. TURNER, Chicago: The Committee wishes to present the following report:

A study of recent appropriation bills in the 69th General Assembly made by the Tuberculosis Control Committee of the Chicago Medical Society, revealed the astounding fact that the Chicago State Tuberculosis Hospital will not be able to operate at full capacity under the provisions of the budget set up in S.B. 495. This problem was presented to the Council of the Chicago Medical Society at its last meeting on May 3, 1955, and the Council directed the President of the Chicago Medical Society to call a meeting of the responsible authorities of the Municipal Tuberculosis Sanitarium, the Cook County Hospital institutions and the Illinois State Department of Public Health. This meeting was called by the President of the Society on May 16, 1955. The authorities present were Dr. E. E. Irons, President of the Chicago Municipal Tuberculosis Sanitarium, an outstanding authority in the field of medicine and tuberculosis; Dr. Karl Meyer, Medical Director of Cook County Institutions, well known medical administrator, and Dr. Clifton Hall, Chief of the Division of Tuberculosis of the Illinois State Health Department. This meeting was held to determine whether any means could be found to solve this emergency problem of operating the Chicago State Tuberculosis Hospital at full capacity. Dr. Irons assured the group that the need for the full planned capacity of the Chicago State Tuberculosis Hospital was urgent. He stated that the beds would be needed because of the increasing number of cases being found by the Chicago Municipal Tuberculosis Sanitarium under new case finding programs, and assured the group that there would be more than enough cases to keep the Chicago State Tuberculosis Sanitarium, the Chicago Municipal Sanitarium, and the Oak Forest Tuberculosis Sanitarium filled to capacity for the next several years. Dr. Karl Meyer stated that there could be no justification for not operating a hospital at full capacity for which it was planned.

The group found no solution for opening up these needed beds unless the State Legislature changes the present budget provisions as defined in S.B. 495. These changes would require an increase in the personnel budget of the Chicago State Tuberculosis Hospital to provide sufficient personnel to operate the hospital at full capacity and further require that the State subsidy for tuberculosis hospitals should be increased from $3,800,000 to $5,000,000.

The Committee recommended that the Chicago Medical Society use all the means at its command to persuade the 69th General Assembly, the Governor and the Director of the Illinois State Budget Commission to provide these needed funds. We would therefore recommend to the Council of the Illinois State Medical Society that it request authorization from the House of Delegates to use all the means at its command to publicize the necessity for prompt corrective action by the 69th General Assembly of the Illinois State Legislature and that its recommendations should be forwarded to the Governor of the State of Illinois, to the Lt. Governor of the State of Illinois, to the Speaker of the House of Representatives, to the Chairman of the Illinois State Budget Commission and to all the members of the Senate and the House of Representatives of the 69th General Assembly.

Respectfully submitted,

(Signed) GEORGE C. TURNER, M.D., Chairman

THE PRESIDENT: This report will be referred to Dr. Whiting's Committee, on reports of Standing Committees.

The Chair recognizes Dr. Albyn Wolfe of Morgan County.

DR. ALBYN WOLFE, Jacksonville: I wish to present a resolution at the request of Dr. George Drennan from the Section on Pediatrics.

Whereas, the Illinois State Budget Commission has recommended the elimination of funds for payment for care of premature infants in three state sponsored premature centers, and

Whereas, these centers with their special facilities perform a valuable service in transporting and caring for premature infants from communities where adequate facilities do not exist, and

Whereas, these centers conduct training courses for nurses from smaller hospitals in the care of premature infants, and

Whereas, valuable research has been carried on in these centers, and

Whereas, Illinois has one of the best statewide premature care programs, and statistics show that premature mortality has been reduced since the establishment of these centers, and

Whereas, the lives of some of these babies would be endangered by the elimination of the program, and

Whereas, reduction in funds for premature care may result in lowering health faciilities in Illinois,

Therefore be it resolved, that the Illinois State Medical Society request the State Administration to provide sufficient funds for operation of Premature Centers throughout the state.

THE PRESIDENT: This resolution will be referred to Reference Committee "D", Dr. C. Elliott Bell, Chairman.

The Chair recognizes Dr. Eliot P. Burt of Peoria County.

DR. ELIOT P. BURT, Peoria: I wish to present a resolution from the Section on Preventive Medicine and Public Health.

Relative to Senate Bill 669, 69th General Assembly, dealing with the status of Physicians, Nurses and other professional persons now covered by the State Civil Service System.

Whereas, House Bill 669 "exempts" from the classified civil service of the State:

"All medical doctors regularly licensed under the laws of this state."

"All teachers certificated pursuant to the provisions of Article 21 of "The School Code", approved May 1, 1945, as amended."

"All members of trades and professions registered by the Department of Registration and Education under the laws of this State",

and

Whereas, the Preventive and other Public Health Services are rendered best for the benefit of the people of Illinois under a system where Physicians, Nurses and other personnel trained and experienced in Public Health are employed for long term continuous service, and

Whereas, public health in Illinois has progressed effectively when physicians and other professional personnel have been covered by the Civil Service System, and

Whereas, the Preventive and other Public Health Services of the State government should be available or provided to all persons of the State without any partisan interest being involved, and

Whereas, the State Medical Society believes that the over-all Medical Services in Public Health can be satisfactorily practiced only by physicians trained, qualified, and dedicated to this particular field, and that physicians with these qualifications cannot be readily obtained under a system of political appointments.

Therefore be it resolved, that the Section on Preventive Medicine and Public Health of the Illinois State Medical Society respectfully and urgently requests the House of Delegates and the Council of the Society to actively oppose this bill at all stages of its progress in the State Legislature.

THE PRESIDENT: This resolution will be referred to Dr. Whiting's Committee on Reports of Standing Committees.

The President: We now come to communications. The Secretary has none, so we will pass to the Election of Emeritus Members. The Secretary will read the list.

Baldwin, Herschel E., 139 N. Vermilion St., Danville, Vermilion

Corbett, Mitchell S., 949 Elmwood Avenue, Oak Park, C.M.S.

Diestelmeier, Edward A., 223 W. Stephenson, Freeport, Stephenson

Heeley, Louis A., 113 S. High St., Belleville, St. Clair

Knowles, Henry, 407 W. Spring St., Anna, Peoria

Mautz, George J., 407 S. 7th St., Springfield, Sangamon

Potts, Frank R., Lacon, Peoria

Rinder, Carl D., 120 Clinton Ave., Oak Park, C.M.S.

Seidel, Albert W., 210 Merrill Ave., Park Ridge, C.M.S.

Southwick, Harry H., 608½ Capitol Ave., Springfield, Sangamon

Wright, Frank, 325 Fullerton Parkway, Chicago, C.M.S.

THE SECRETARY: These men have been approved and given classification by their respective component societies and they are asking this House of Delegates to elect them.

DR. W. E. KITTLER, Rochelle: I move that the men listed by the Secretary be elected to Emeritus Membership. (Motion seconded by Dr. Caesar Portes, Chicago, and carried).

THE PRESIDENT: We now come to the election of Retired and Past Service Members. The Secretary will read the list.

RETIRED

Allen, Arthur V., Route 2, N. Little Rock, Ark., C.M.S.

Colteaux, John A., Roberts, Ford

Hodes, J. Ellis, 416 Wisner Ave., Park Ridge, C.M.S.

Keiser, Harry R., 2126 Farrell Ave., Chicago, C.M.S.

Kerekes, Joseph, 5352 N. Washtenaw Ave., Chicago, C.M.S.

Lyon, Will F., 9800 Vanderpoel Ave., Chicago, C.M.S.

Pok, Anton J., 5629 S. Artesian Ave., Chicago, C.M.S.

Rundstrom, K. C., 1235 Fair Oaks, Oak Park, C.M.S.

DR. WILLIS I. LEWIS, Herrin: I move that these men be elected to Retired Membership. (Motion seconded by Dr. George C. Turner, Chicago, and carried).

PAST SERVICE

Costeff, Harry, 1109 N. Madison Ave., Peoria, Peoria

Hulick, Charles H., Shelbyville, Shelby

Langhorst, Arthur L., 164 Division St., Elgin, Kan.

THE SECRETARY: I would like to say that Dr. Charles H. Hulick was a member of the Council for a number of years. He has had a serious cerebral accident and for many months he has been unconscious. Last year he was totally disabled throughout the year and Mrs. Hulick paid the dues to the A.M.A. and the County Society. We recommended that the County Society investigate and see if they wanted to recommend him for Past Service Membership, and they have done so.

DR. W. W. FULLERTON, Sparta: I move these men be elected to Past Service Membership. (Motion seconded by Dr. Walter E. Kittler, Rochelle, and carried).

THE PRESIDENT: As there is no other new business we will pass to Reports of Reference Committees. The first is the report of the Committee on Reports of Officers, Dr. Tom Kirkwood, Chairman.

Report of the Committee on Reports of Officers

To the Members of the House of Delegates:

Report of the President

Your Committee commends our President, Dr. Arkell M. Vaughn, for his conscientious attention to the arduous duties associated with his office during the past year. He has travelled extensively, having visited all of our neighboring states. He has attended meetings on both coasts and many other professional conventions. He has represented our Society at receptions for famous European visitors and also at testimonial dinners honoring some of our outstanding members.

Our President has given full credit to all officials of our organization for the assistance and cooperation which they have so willingly given him in carrying on his work. Their readiness to cooperate so effectively testifies to the fact that he has been a very popular president who deserved the confidence and respect of his associates. He is especially grateful to our able Secretary, Dr. Harold M. Camp, and his staff in Monmouth and Chicago for their assistance during his term of office.

Your Committee would suggest that the President and the Council continue the policy of having county society officials and other members of the Society as guests at Council meetings. This gives any member in the Society an opportunity to get a better idea of how the Council and other State Society officials conduct our business, and a better understanding of the problems which these men have to solve. We feel that the President and the Council should be highly commended for their efforts in this direction.

The President's comments on the Committee on Medical Service and Public Relations of which Dr. Percy E. Hopkins is Chairman, deserves special consideration. The accomplishments of Dr. Hopkins and this Committee have been outstanding, and the present arrangement which enables our Counsel, John W. Neal, and his associate, Walter L. Oblinger, to keep every one in the state in touch with what is going on in Springfield and elsewhere, gives us an excellent opportunity to protect the welfare of the public. What is genuinely good for the public is likewise good for us.

The President's statements concerning the Committee on Medical History of which Dr. James H. Hutton is chairman, demonstrates his interest in completing Volume II of the History of Medical Practice in Illinois.

Dr. Vaughn attended every meeting of this Committee. Dr. Hutton is to be congratulated on the fine work he has done as Chairman of this Committee. This project could not have been completed without the splendid cooperation of the members of the Council. We deeply regret the death of Dr. D. J. Davis, who was the Editor of Volume II and a valued member of the Committee.

Dr. Vaughn has had excellent cooperation from the Postgraduate Education Committee under the chairmanship of Drs. Limarzi and Kirby, and from the Scientific Service Committee of which Dr. Limarzi is also the Chairman, ably assisted by Miss Ann Fox. He also mentions the valuable service rendered by the Woman's Auxiliary. The improvements in our Journal are noted and are outstanding.

Dr. Vaughn's entire report demonstrates his ability as an administrator and his ability to cooperate with, and to stimulate his associates.

(DR. KIRKWOOD: I move the adoption of this portion of the report. Motion seconded by Dr. John Long, Robinson, and carried).

Report of the President-Elect

Your Committee has reviewed the report of our President-Elect, Dr. F. Garm Norbury, and has unanimously decided that we have again selected a gentleman and a scholar as our next President. His remarks concerning his ability as a knife and fork man have been read with interest and we hope that his digestive apparatus will be able to cope with the assaults made upon it during the next year. We also hope that his interest and efforts in coordinating the work of organized medicine with that of the Departments of Public Welfare and other state departments will continue and that they will meet with continued interest.

Your Committee is confident that Dr. Norbury's experience during the past year have eminently fitted him for his duties as President of our Society, and we are looking forward to another successful year during his administration.

(DR. KIRKWOOD: I move the adoption of this portion of the report. Motion seconded by Dr. Walter E. Kittler, Rochelle, and carried).

Report of the Secretary-Treasurer

Your Committee has examined the report of our Secretary-Treasurer, Dr. Harold M. Camp, and suggests that it should be read and studied by every delegate before he reports to his component Society. This report is comprehensive and complete and gives an excellent account of the Society's activities and financial status during the last year. It indicates that our Society is in a healthy condition financially and otherwise, and that we are adding new members every year.

The Committee is especially interested in the enormous amount of work turned out by the Monmouth and Chicago offices, and suggests that the Council review this problem with the idea of providing additional help where needed. We also suggest the possibility of a general office manager in the Chicago office, who could coordinate the work of the various departments in this city. Our Journal is edited here, our Council meets here, our annual meetings are in this city. A general manager here could relieve Dr. Camp of some of his work and thus give him more time for his duties in Monmouth and elsewhere. With this in mind we feel that it may be advantageous to every one to concentrate as much of our work as possible, outside of that conducted in the Monmouth office, in the new quarters which will be occupied by the Chicago office.

Your Committee appreciates the great loss to the Society and to the Secretary occasioned by the death of James C. Leary, and extends our sympathy to his family.

The Physicians' Placement Service has set a pattern which has been followed by many states and deserves great praise.

The Secretary's intense interest in the welfare of the State Society is demonstrated by his perfect attendance at every Council meeting for the last 33 years. The Committee recommends that the Council consider the appointment of an assistant to the Secretary if such an appointment would relieve him of some of the numerous details and responsibilities of his work.

The Committee extends its thanks to the Secretary's clerical force, Frances C. Zimmer, Jane Zimmer Swanson, Wanda Ross, and Mary Ward, and to Miss Ann Fox, Clara Mai Rutherford and others in the Chicago office. Without their assistance we could not go very far.

The general expense of conducting the Society's business seems to be most reasonable and the Committee is well satisfied with the financial report.

(DR. KIRKWOOD: I move the adoption of this portion of the report. Motion seconded by Dr. E. E. Davis, Avon, and carried).

This report is signed by Drs. G. Henry Mundt, Anders J. Weigen, Lawrence F. Rockey, Darrel H. Trumpe, and Tom Kirkwood, Chairman.

(DR. KIRKWOOD: I move the adoption of the report as a whole. Motion seconded by Dr. E. A. Lukaszewski, Chicago, and carried).

THE PRESIDENT: The next report is from the Committee on Reports of Councilors, Dr. Percy E. Hopkins, Chairman.

Report of Committee on Reports of Councilors

This Committee was to receive and report on the reports of: (1) the Chairman of the Council, (2) the Councilors of the eleven councilor districts, and (3) the councilor-at-large.

This Committee in reviewing the reports of the various councilors is impressed by the fact that many of the items contained in the reports are the subject of reports of other committees, and it has therefore assumed that where such situations occur, the specific reports of the committees will be reviewed elsewhere in much greater detail, and has, therefore, in an effort to avoid repetition, not gone into detail with regard to some of these reports.

The Committee notes in the report of the Chairman of the Council a recommendation referring to the wisdom of reviving the previous television effort in connection with the Educational Committee.

The Chairman of the Council appeared in person before the Committee, as did the Chairman of the Educational Committee, and provided sound logic for the desirability and necessity for this program again appearing on television. Many problems having to do with sponsors, salaries, unions, etc., were discussed by the Committee, and the Committee feels that these matters are not problems to inflict on the House of Delegates, but are matters for the committee to decide. The Reference Committee has complete confidence in the ability of the Educational Committee to solve these details satisfactorily.

In the Second Councilor District, the Committee notes with pride and approval the announcement of a Community Hospital being the recipient of a community fund for the provision of a number of new beds. It was with considerable satisfaction that the Committee observed this event, and commends the Councilor for his support of this project, which utilized the principles of the community being responsible and able to provide for its own needs in this respect.

In the report of the Councilors from the Third District it was noted that the activities of the county medical society are numerous and extensive. The existence of a grievance committee which has been in satisfactory operation for a long period of years, and which has been used as a pattern for other state and county organizations throughout the land is noted with pride.

A Doctor's Emergency Medical Service is a going organization in this Society, having answered more than 4,000 emergency calls in the last year.

The Ethical Relations Committee, and the Committee to Investigate Informal Charges of Unethical Practice continue to function well, and only a very small number of transgressions were found to exist in the organization during the last year.

The Clinical Conference put on by the Chicago Medical Society has now been extended over a period of four days, with an attendance of doctors from all over the country, numbering more than 3,600 on the last occasion.

This Clinical Conference has developed into an outstanding event, as has the two-week postgraduate courses offered each fall, which likewise attracts physicians from all over the United States and Canada.

The Tuberculosis Control Committee has done much to bring about a favorable tuberculosis situation in Chicago. Undoubtedly a more detailed review of the problems and progress of the Tuberculosis Control Committee will be made by the Reference Committee having to do with the report of this Committee.

The activities of the Chicago Medical Society in its Child Health Program in the Chicago schools has resulted in a situation which has never been more favorable.

The growth of Illinois Medical Service will be referred to elsewhere, and is an outstanding achievement for the physicians in the Third Councilor District.

The Committee notes the reporting of four malpractice suits in the Fourth Councilor District, which is disturbing, but has no other comment to make in that regard.

The report of the Councilor from the Fifth District reflects the activity of a vigorous, industrious doctor, who is entitled to much commendation for his many activities on behalf of organized medicine. Residing in Springfield where much of the activity of the Illinois State Medical Society occurs, Dr. Reisch is called upon frequently to render extracurricular service, and is deserving of commendation for his efforts in connection with the dinner meeting honoring Dr. Roland Cross, to which the legislators were invited, as well as for his activity in putting on the Secretaries' Conference, and the many other contacts he is required to make because of his location.

The Councilor of the Eighth District calls the attention of the House of Delegates to the vital need for the retention of nurses' training schools. The Committee, cognizant of the need for the continuation of these schools in order that proper health care may be provided for the citizens of the state; feels that this subject is a matter that will be properly referred to in much greater detail elsewhere.

The Councilor of the Ninth District brings to the attention of the House of Delegates some of the problems of the I.P.A.C., and the need for the urging of the county medical societies and membership to cooperate in helping control these problems.

The Committee is well aware of the fact that Dr. Montgomery has had many serious problems confront him, and feels that he has been remarkably efficient in conducting this Committee during the past year. It is not an easy task to pursue a straight course while being confronted from many angles by people with various interests.

The Committee feels that Dr. Montgomery has done an outstanding job, and is deserving of much commendation for his activities. His report will, of course, be discussed in detail elsewhere.

The Committee feels that the House of Delegates should acknowledge with gratitude the organization of a new county medical society, organized with the aid and cooperation of the Councilor of the 11th District, in Kendall County, inasmuch as this is the first new county medical society to be so organized in the past fifty years.

The comments of the Councilor-at-Large in regard to the desirability of the continued participation of the Illinois State Medical Society in the American Education Foundation setup is wholeheartedly endorsed by the Reference Committee.

Reports of all of the Councilors show a definite and sustained interest in the activities of the Illinois State Medical Society, and the Committee recommends that the Councilors be commended for their enthusiasm and effort.

It is noted that postgraduate courses arranged for by the Postgraduate Education Committee of the State Society have been presented in practically all Councilor Districts. These Conferences have been of excellent caliber, have been well attended in most instances, and are of value in bringing doctors of a district together, and allowing them to become much better acquainted with each other in the development of their common interests.

(DR. HOPKINS: I move you the adoption of this report. Motion seconded by Dr. C. Paul White, Kewanee, and carried).

This report is signed by Drs. Edward Helfers, Allison Burdick, William Scanlan, Norman Sheehe, and Percy E. Hopkins, Chairman, whom I thank for their participation.

THE PRESIDENT: We will digress from our usual procedure and ask Dr. Edwin S. Hamilton to introduce a prominent guest.

DR. HAMILTON: Mr. President and Fellow Delegates, and Guests: It is a great pleasure to be able to have the opportunity of presenting to you the Vice-Chairman of the Board of Trustees of the American Medical Association, and Chairman of the Executive Committee of the Board of Trustees of the A.M.A., I have had the pleasure of working with him for seven years in the Executive Committee and I cannot recommend him as highly to you as I would like. He is an indefatigible worker, gives of his time and energy and money to his work. He is down here today and I want to present Dr. Gunnar Gunderson of La-Crosse, Wisconsin.

DR. GUNDERSON: Dr. Hamilton, Dr. Camp. Dr. Furey, Mr. Chairman and Members of the House: I want to thank my friend Ed Hamilton for his very generous introduction. I had no intention of appearing before you. I was in Chicago on A.M.A. business and had a few minutes before catching a plane. It is certainly a great pleasure to see this large crowd working in the interests of organized medicine. I am acutely aware of working medicine at the cross roads, having come up from the cross roads. I am highly honored to appear before the Illinois group. In Wisconsin we are acutely aware of the camaraderie and fine support that exists in medicine in the north central states, Minnesota, Michigan, Wisconsin, Iowa, and Illinois. I consider it a single honor to be with you today. I did not come here to make a speech. I appreciate, Mr. Chairman, being invited to speak.

THE PRESIDENT: Thank you Dr. Gunderson. We will continue with the reports and will hear from Dr. Warren W. Furey, Chairman of Reference Committee "A" on Reports of Council Committees.

Report of Reference Committee "A" on Reports of Council Committees

Reference Committee "A" on Reports of Council Committees had before it several matters for consideration and offers the following for your action:

1. Report of Editorial Board and Journal Committee, page 76 of the Handbook.

Dr. Hutton, Chairman of the Committee, discussed the report as presented and stressed the need for more frequent meetings. Your Reference Committee concurs in the suggestion that the Board should meet more often and has been assured by the Editors that such meetings can and will be held. Dr. Hutton and the Committee members are to be commended for their active interest and helpful recommendations.

(DR. FUREY: I move the adoption of this section of the report. Motion seconded by Dr. J. J. Moore, Chicago, and carried).

2. Report of Editors, Illinios Medical Journal, pages 76-78 of the Handbook.

The Reference Committee reviewed the report with interest and wishes to congratulate the editors, the Editorial Board and the Journal Committee for their efforts to improve the Journal and urges further study to assure continuation of this fine work.

Particular commendation should be made on the excellent improvement shown in the format and in the type and quality of scientific material contained in the Journal during the past year.

In line with the final paragraph of the report asking for comments and recommendations for changes or improvements we offer the following:

1. A continued effort should be made to secure high grade articles, from both local and national sources, and
2. That an effort be made to publish articles with less time interval between submission and publication, special note being made of an article published in May, 1955, which had been presented at the State meeting in May, 1953.

Again congratulations to Drs. Camp and Van Dellen and to Mr. L. E. Malley for their outstanding contributions to the success of our Journal.

DR. FUREY: I move the adoption of this section of the report. Motion seconded by Dr. Mather Pfeiffenberger, Alton, and carried).

3. Report of Delegates to the A.M.A., pages 78-82 of the Handbook.

This report was carefully reviewed and discussed; it represents a factual story of the work of your delegates to the A.M.A. and of the many and varied activities of the body in the affairs and problems of American medicine.

Your Reference Committee commends the delegates for their diligence and wishes to pay special tribute to the Chairman of the delegation for the excellence of his report.

(DR. FUREY: I move the adoption of this section of the report. Motion seconded by Dr. Walter E. Kittler, Rochelle, and carried).

4. Report of the Advisory Committee to the I.P.A.C., pages 82-88 of the Handbook.

This report details the workings, trials and tribulations of one of the outstanding committees of the Illinois State Medical Society. This Committee has, over the years, served to maintain the highest quality of medical care rendered the public aid recipients in the state and at the same time has done an outstanding job on behalf of the physicians of Illinois charged with the responsibility for giving that care. The problems are many and often serious enough to make committee members wish for an easy way out. Their faith in the philosophy that this care is to be rendered as deemed necessary by physicians, freely selected by the patients without dictation by an overall authority has, however, encouraged them to carry on.

You are urged to read this report carefully and to cooperate in every way possible with recommendations of the committee.

The Chairman of this Committee has been most outstanding in this work. He and his Committee are to be commended most highly.

(DR. FUREY: I move the adoption of this section of the report. Motion seconded by Dr. Percy E. Hopkins, Chicago, and carried).

The supplementary report, presented orally is evidence of the continuing effort of this Committee to discharge its responsibilities in the interest of both the public and the physician.

One section of the main report, the editorial from the Mississippi Valley Medical Journal, November 1950, on page 86 of the Handbook, contains certain suggestions which if adopted would constitute an official action of the Society, for that reason the Reference Committee recommends deletion of the last sentence in paragraph one starting with "While we are not prepared at this time to suggest a remedy", etc., and the next paragraph "Fees for X-ray service, etc."

(DR. FUREY: I move the adoption of this section of the report. (Motion seconded by Dr. Percy E. Hopkins, Chicago, and carried.). I now move the adoption of the report and supplement as amended. Motion seconded by Dr. Earl Blair, Chicago, and carried).

5. Advisory Committee to American Legion, pages 89-90 of the Handbook.

This report was carefully considered and is recommended for your favorable action. This Committee has maintained liaison with a most important group of outstanding American citizens and is to be highly commended for the excellence of the work they have done.

(DR. FUREY: I move the adoption of this section of the report. Motion seconded by Dr Mather Pfeiffenberger, Alton, and carried).

6. Advisory Committee to the Veterans Administration, pages 90-91 of the Handbook.

This report deals with the services rendered eligible veterans in Illinois by participating physicians under contract between the Illinois State Medical Society and the Veterans Administration. It was pointed out that the present fee schedule is no longer adequate, having been in force over a period of many years. It is suggested that consideration be given to a revision which would not only be more realistic, but would be more in keeping with present economic conditions; this could be done at the time of contract renewal.

(DR. FUREY: I move the adoption of this section of the report. Motion seconded by Dr. Charles P. Blair, Monmouth, and carried).

7. Resolution titled "Drug Dispensing, pages 178-179 of the Handbook, was generally discussed and favorably considered; however, it should be pointed out that the Illinois State Medical Society is not in a position to rescind or eliminate any section of the Principles of Medical Ethics of the A.M.A. We, however, can make recommendations and suggestions for such changes. Therefore, we suggest adding to the first resolve the following: "that Section VIII, Chapter 1, of the Principles of Medical Ethics be referred to the House of Delegates, the Judicial Council and the Constitution and By-Laws Committee of the A.M.A with the suggestion that it be deleted and the following substituted."

(DR. FUREY: I move the adoption of this section of the report, which will carry with it the resolution as amended. Motion seconded by Dr. W. W. Fullerton, Sparta, and carried).

8. Resolution of Ford County Medical Society, pages 179-180 of the Handbook, having to do with drug allowances and resignation of the Ford County Medical Advisory Committee to the I.P.A.C. This was discussed at length in connection with the supplementary report of the Advisory Committee to the I.P.A.C. which brought the information that an agreement had been reached with the I.P.A.C. granting a 20% mark-up for drugs. It is the feeling of the Reference Committee that the complaint voiced in the resolution has been answered by the supplementary report, and, therefore, recommends that the resolution be not adopted.

(DR. FUREY: I move the adoption of this section of the report, meaning that the resolution will not be adopted. Motion seconded by Drs. Walter E. Kittler, Rochelle, and Harry Mantz, Alton, and carried).

(DR. FUREY: I move the adoption of the report as a whole as amended. Motion seconded by Drs. George C. Turner, Chicago, and C. Paul White, Kewanee, and carried).

Our thanks to those who appeared before the Committee, they were most helpful in the deliberations. Thanks, from the Chairman to the Committee members and alternates, we had a very pleasant session. The report is signed by Drs. Eugene T. McEnery, Charles H. Phifer, George B. Callahan, J. A. Mathis, Peter C. Rumore, and Warren W. Furey, Chairman.

THE PRESIDENT: We will now hear the report of Reference Committee "C", Dr. Frank H. Fowler, Chairman.

Report of Reference Committee "C" on Reports of Council Committees

1. *Crippled Children's Clinics*

The Reference Committee wishes to commend the fine work done by this Committee, aided by Dr. Frank G. Murphy, and also the physicians participating in these crippled children's clinical programs.

Also, we wish to commend the organizations that have made these services available to the crippled children in the state of Illinois, namely, the National Foundation for Infantile Paralysis, Illinois Association for the Crippled (Easter Seals), the Illinois Elks Association Crippled Children's Commission, the Shriners' Crippled Children's Organization, and the many other university and hospital clinics that care for these patients.

It has been recommended to the Committee that the dates for holding these clinics be publicized with the county societies, so that every physician will know when these clinics are being held in their community.

DR. FOWLER: I move the approval of this portion of the report. Motion seconded by Dr. Robert R. Mustell, Chicago, and carried).

2.The Committee to Investigate the Coroner's Office (Act).

The Committee to investigate the coroner's office has made a thorough study of the problem, and should be given a vote of thanks for their arduous work.

Bills Nos. 247 and 248 which have been introduced into the State Senate, have been passed unanimously by the Judiciary Committee with minor revisions, which have been very acceptable to the Committee, and within the next few days will be voted upon by the State Senate. If it is passed by the Senate, it will go before the House within the next week.

We believe that the Society should do everything in its power to support these bills, so that the handling of coroner's cases will be on a high professional level.

Again we wish to commend Dr. Samuel Levinson, Dr. Harlan English, Dr. C. Paul White and Dr. Edwin F. Hirsch and Dr. Franklin Moore for their untiring efforts in the matter of investigation and testifying before the legislature in Springfield.

(DR. FOWLER: I move the approval of this portion of the report. Motion seconded by Mather Pfeiffenberger, Alton).

DR. C. HENRY MUNDT, Chicago: Would it not be more politic if we eliminated the term, "investigate the coroner's office", that does not sound very good. I know what it is but I question whether that will not be misunderstood in certain places.

DR. C. PAUL WHITE, Kewanee: It is to be remembered that that Committee has been working for over a year under that caption. The caption is in Springfield. I do not know whether we want to change it.

DR. FOWLER: I do not think I can do anything about it. This is a Council committee and they gave the title. (Motion to approve this portion of the report was carried).

3. *Committee on Diabetes*

The Committee wishes to state that this Committee has had no meeting during the year.

(DR. FOWLER: I move the adoption of this portion of the report. Motion seconded by Dr. E. S. Hamilton, Kankakee, and carried).

4. *Educational Committee*

Through the untiring efforts of Dr. Charles P. Blair, Dr. Karl L. Vehe, Dr. George Byfield, Dr. George L. Drennan, and Dr. Harlan English this Committee has been one of the most important committees of the State Society for many years.

The Committee regrets that during the past year that the television programs, which were of such great interest to the public have been discontinued, due to the lack of a sponsor.

The Committee wishes to recommend to the House of Delegates that this Committee investigate the possibility of procuring a sponsor, or sponsors, so that these programs may be resumed in the near future, with the power to act with the permission of the Executive Committee of the Council, or the Council, in obtaining a sponsor.

(DR. FOWLER: I move the adoption of this portion of the report. Motion seconded by Dr. Charles H. Phifer, Chicago).

DR. CHARLES P. BLAIR, Monmouth: I am sure it is a stenographic error that the name of Dr. L. S. Reavley was omitted from that Committee.

DR. FOWLER: I will add it. The name of Miss Ann Fox was also omitted. I will add that. (Motion to adopt this section of the report was carried).

5. *Sub-Committee on School Health*

This committee has had a very short report in the Handbook. However, it has been one of the most active committees in the Medical Society. Drs. Drennan, Reichert, Shafton, Crawford, Nolan and Fullerton have given much of their time to the School Health Program, and the Committee believes due to their efforts these programs are being handled by the members of the State Medical Society, instead of lay organizations.

We wish to compliment this Committee on a fine job well done.

(DR. FOWLER: I move the adoption of this portion of the report. Motion seconded by Dr. C. P. Eck, Chicago, and carried).

6. *Ethical Relations Committee*

The Ethical Relations Committee, we are happy to say, has had no cases referred to it.

It is with great sorrow that we have lost the Chairman of the Committee, Dr. Arthur C. Taylor, who was also the Chairman of the Ethical Relations Committee of the Chicago Medical Society.

(DR. FOWLER: I move the adoption of this portion of the report. Motion seconded by Dr. J. J. Moore, Chicago, and carried).

7. *Fifty Year Club*

Andy Hall is still the guiding light of the Fifty Year Club, as he has been the guiding light in medicine during the last sixty years. We owe a great deal to Dr. Hall for his inspiration and service to the Society. We wish that the Fifty Year group had over twice its membership, so that the necrology report would be much smaller.

(DR. FOWLER: I move the adoption of this portion of the report. Motion seconded by Dr. Anders . Weigen, Chicago, and carried).

8. *Interprofessional Relations*

The Committee wishes to accept this report without comment.

(DR. FOWLER: I move the adoption of this portion of the report. Motion seconded by Drs. George C. Turner, Chicago, Anders J. Weigen, Chicago and Charles P. Eck, Chicago, and carried).

(DR. FOWLER: I move the adoption of the report as a whole. Motion seconded by Dr. W. W. Fullerton, Sparta).

DR. G. HENRY MUNDT, Chicago: It is not a good title, Committee to Investigate the Coroner's Act would be better.

DR. C. PAUL WHITE, Kewanee: The Committee has been working under the direction of the Council for more than two years. We failed to get recognition in the last legislature. Dr. Hirsch did most of the work. We have worked under that title. I do not think we should change it. I would suggest you make a change in the report from "office" to "act".

DR. HARLAN ESGLISH, Danville: It should be "act".

DR. FOWLER: I will be glad to amend the report and change that to "act". I would move that the report in the Handbook be corrected, that it should be, "to investigate the coroner's act", and that the Committee be called, "Committee to Investigate the Coroner's act". (Motion seconded by Dr. E. S. Hamilton, Kankakee, and carried).

DR. FOWLER: I move the adoption of the report as a whole as amended. (Motion seconded by Dr. George C. Turner, Chicago and Dr. E. A. Lukaszewski, Chicago, and carried).

The Chairman appreciates the work of the Committee. The report is signed by Drs. Carl F. Steinhoff, Joseph Sodaro, H. J. Nebel, N. A. Thompson and Frank H. Fowler, Chairman.

THE PRESIDENT: As there are no other reports ready for presentation, I will entertain a motion for adjournment.

DR. MATHER PFEIFFENBERGER, Alton: I move we adjourn to meet Friday morning at 8:30. (Motion seconded by Dr. J. J. Moore, Chicago, and carried).

The meeting adjourned at 4:50 P.M.

« « « » » »

The third session of the House of Delegates of the Illinois State Medical Society was called to order on Friday, May 20, 1955, at 8:45 A.M. by the President, Dr. Arkell M. Vaughn, Chicago.

THE PRESIDENT: The first order of business is the report of the Credentials Committee, Dr. Harlan English, Chairman.

DR. HARLAN ENGLISH, Danville: The attendance slips show that a quorum is present. I move that the attendance slips checked against the voting record, showing that a quorum is present, constitute the voting strength of this meeting. (Motion seconded by Dr. Walter E. Kittler, Rochelle, and carried).

THE PRESIDENT: The next item of business is the roll call by the Secretary.

THE SECRETARY: You have the attendance slips checked, but I will be glad to call the roll if you want it.

DR. E. A. LUKASZEWSKI, Chicago: I move that we dispense with the roll call. (Motion seconded by Dr. J. J. Moore, Chicago, and carried).

THE PRESIDENT: The next item is the reading of the minutes of the previous session.

DR. CHARLES H. PHIFER, Chicago: I move that the reading of the minutes be dispensed with. (Motion seconded by Dr. H. Close Hesseltine, Chicago, and carried).

THE PRESIDENT: The next item on the agenda is the announcement of awards to scientific exhibitors, Dr. Coye C. Mason, Chairman and Director of Scientific Exhibits.

1955 EDUCATIONAL VALUE

Gold Medal — Booth 10
Title: "Cutaneous Tumors"
Exhibitor: Julius E. Ginsberg
Institution: Northwestern University Medical School, Department of Dermatology.

Silver Medal — Booth 4
Title: "Oral Pathology"
Exhibitor: A. G. Anderson, M. Marvin Weiss, I. Harris
Institution: Veterans Administration Hospital.

Bronze Medals — Booths 6 and 9
Title: "Conservative Management of Diabetic Foot Complications"
Exhibitors: William L. Lowrie, W. Earl Redfern, Brock E. Brush
Institution: Henry Ford Hospital
Title: "Rheumatoid Arthritis"
Exhibitors: Eugene F. Traut, Chester B. Thrift, Joseph E. Allegretti, Paul Carstens, Harriet M. Clark and Arthur R. Fisher
Institution: Arthritis Clinic of Cook County Hospital, Hektoen Institute.

1955 — ORIGINAL WORK

Gold Medal — Booth 5
Title: "Surgical Treatment of Congenital Cardiovascular Anomalies"
Exhibitors: William L. Riker, Arthur DeBoer, Thomas Baffes and W. J. Potts
Institution: Children's Memorial Hospital of Chicago

Silver Medal — Booth 11
Title: "Illustrations of the Liver in Health and Disease"
Exhibitor: Frank Netter, Hans Popper.
Institution: Hektoen Institute for Medical Research of Cook County Hospital

Bronze Medals — Booths 7 and 14
Title: "EEG Abnormalities in Endocrine Disease"
Exhibitor: Joseph Condon, Dorothy Becka, F. A. Gibbs
Institution: Veterans Administration Hospital, Hines
Title: "BCG Vaccination Against Tuberculosis"
Exhibitor: Sol Roy Rosenthal, Philip G. Rettig
Institution: Research Foundation, Institution for Tuberculosis Research at the University of Illinois, Municipal Tuberculosis Sanitarium, and Cook County Hospital.

DR. MASON: It might be of interest to you to know that 13 exhibits presented were original exhibits and will be shown at the A.M.A. next year. I wish to thank the members of my Committee, Drs. Arkell M. Vaughn, Dwight E. Clark, Leo M. Zimmerman, L. W. Peterson, Harold L. Method, J. C. Thomas Rogers, and Everett P. Coleman.

THE PRESIDENT: We now come to the election of officers.

For President-Elect, F. Lee Stone of Chicago was nominated by M. M. Hoeltgen second by H. Close Hesseltine. There being no additional candidates, the Secretary was instructed to cast the affirmative ballot for Dr. Stone, and he was elected.

Jacob E. Reisch nominated C. Elliott Bell of Decatur for the office of 1st Vice President, 2nd by J. Mather Pfeiffenberger. Dr. Bell was elected.

Frank H. Fowler nominated M. M. Hoeltgen for the office of 2nd vice president second by Anders J. Weigen. Dr. Hoeltgen was elected.

Walter E. Kittler nominated Harold M. Camp to succeed himself as Secretary-Treasurer, second by F. Lee Stone. Dr. Camp was elected.

ELECTION OF COUNCILORS

1st District; Carl E. Clark, Sycamore, was re-elected to fill the unexpired term of Joseph S. Lundholm, deceased.

3rd District; J. Lester Reichert and H. Close Hesseltine were elected to succeed themselves for a three year term.

4th District; Charles P. Blair, Monmouth was re-elected for a three year term.

5th District; Jacob E. Reisch, Springfield was re-elected for a three year term.

7th District; Arthur F. Goodyear, Decatur was re-elected for the three year term.

8th District; Harlan English, Danville, was re-elected for a three year term.

ELECTION OF DELEGATES TO THE A.M.A. for a two year term ending December 31, 1957.

The following were elected for the two year term.
H. Kenneth Scatliff, Chicago
Walter C. Bornemeier, Chicago
J. Mather Pfeiffenberger, Alton
Harlan English, Danville
Everett P. Coleman, Canton.

ALTERNATE DELEGATES TO THE A.M.A.

The following elected for a two year term.
Eugene T. McEnery, Chicago
Frank H. Fowler, Chicago
Arthur F. Goodyear, Decatur
Lester S. Reavley, Sterling
E. H. Weld, Rockford

Election of Standing Committees.

a. Medico-Legal Committee.
Leo P. A. Sweeney, Chicago
F. E. Bihss, East St. Louis.
Elected for three year term.

b. COMMITTEE ON MEDICAL EDUCATION AND HOSPITALS.
George F. O'Brien, Chicago
Harlan English, Danville
Karl L. Vehe, Chicago
Elected for term of one year.

c. COMMITTEE ON MEDICAL BENEVOLENCE
Norman L. Sheehe, Rockford elected for 3 year term.
F. M. Nicholson, Chicago elected to fill unexpired terms of Robert H. Hayes who had resigned.

d. COMMITTEE ON MEDICAL TESTIMONY
John H. Gilmore, Chicago
Maurice D. Murfin, Decatur
The above elected for four year term.
Adrien Ver Brugghen, Chicago; elected to fill unexpired term of Oscar Hawkinson, who had resigned on account of his health.

e. GRIEVANCE COMMITTEE
Arkell M. Vaughn, Chicago
Willis I. Lewis, Herrin
The above elected for a three year term.
Harry Mantz, Alton elected to fill unexpired term of T. Gaillard Knappenberger, deceased.

f. THE PERMANENT HISTORIAN.
Tom Kirkwood, Lawrenceville was elected to succeed D. J. Davis, deceased.

Maurice M. Hoeltgen stated that the C.M.S. Delegates would nominate a Councilor to replace F. Lee Stone who had been elected to the office of President-Elect. He placed in nomination, Caesar Portes of Chicago to fill the unexpired term of Dr. Stone. Dr. Portes was unanimously elected as Councilor for the 3rd District.

THE PRESIDENT: The next order of business is fixing the per capita tax for 1956 annual dues.

DR. JOSEPH T. O'NEILL, Ottawa: Mr. President, the Council recommends that the annual dues for 1956 remain as they are, and I so move. (Motion seconded by Drs. Walter E. Kittler, Rochelle, and E. E. Davis, Avon, and carried).

THE PRESIDENT: The next item on the agenda is the presentation of reports of Reference Committees not heard at the Second Meeting of the House on May 19. The first report to be heard will be that of the Reference Committee on Reports of Standing Committees, Dr. William Whiting, Chairman.

Report of the Reference Committee on Reports of Standing Committees

Medical Service and Public Relations (pp. 57-64 of the Handbook): This Reference Committee considered carefully and in detail the report as published in the Handbook. During our discussion we became thoroughly cognizant of the tremendous amount of work performed by this Committee and under its supervision.

We recommend the adoption of this report and commend the Committee for the excellent manner in which this work was done. All of the Reference Committee members are aware of the signal contributions of Mr. James C. Leary and the great loss to our Society that his untimely death means.

Dr. Robert E. Heerens, Rockford, Winnebago County, appeared before the Committee representing his component society and, especially the Public Relations Committee of his society, to emphasize the great importance of adequate, active but discrete public relations to the medical profession today. He stated that it was the feeling in his society that an intensification and expansion of these activities at the state level was in order at this time. Dr. Percy E. Hopkins, Chairman of the Committee, also appeared and concurred in these opinions and pointed out that he could not oppose any effort made by the House of Delegates to accomplish these ends. On the basis of the discussion that followed this Reference Committee would like to make the following recommendations to the House:

1. That the basic Committee be enlarged to include more "grass roots" public relations people from component societies and that this might be implemented under the By-Laws of the Society by taking advantage of the following paragraph of Section 3, Chapter IX, quote, "Each component society shall appoint one member to act as advisor to this committee."

2. That a more comprehensive statewide Public Relations Program be developed to encourage every county society to formulate a local program suitable to the area needs, such as (a) emergency call system, (b) speakers' bureau, (c) new physician contacts, (d) insurance activities, and (e) community service.

3. That closer liaison through the State Society and to the component societies be set up with the public relations department of the American Medical Association so that all groups will have the full benefit of these efforts and materials.

4. Promote the exhange of public relations materials and plans among the component societies of Illinois and act as a clearing house to accomplish this end.

The Reference Committee had the pleasure of meeting and discussing the excellent work in the legislative information field of Mr. Walter L. Oblinger and recommends that his services be continued.

(DR. WHITING: I move the adoption of this portion of the report. Motion seconded by Dr. Robert E. Heerens, Rockford, and carried).

Medico-Legal Committee (pp. 64-65 of the Handbook): Your Reference Committee was interested to note the brevity of the report of the Committee. Inasmuch as important changes are taking place all over the United States in relation to medico-legal matters and, particularly, medical protective insurance and in consideration of the extensive study being made at the present time by the Legal Department of the American Medical Association this committee is confident that there will be important work for the Medico-Legal Committee to perform during the coming year. Dr. George C. Turner, Chairman, attended this meeting and concurred in these opinions.

Your Reference Committee would like to re-emphasize the two recommendations printed in the Handbook:

1. All members of the Society should take stock of their medical liability problems.

2. The members be again reminded by the Society that most suits have their origin in the indiscrete remarks made by members of the medical profession. Another large group has its origin in failure of the doctor to inform his patient as to possible unfavorable results of specific medical conditions.

(DR. WHITING: I move the adoption of this portion of the report. Motion seconded by Drs. Mather Pfeiffenberger, Alton, and Willis I. Lewis, Herrin, and carried).

Archives (p. 65 of Handbook): After reading the report of the Committee as printed in the Handbook your Reference Committee takes great pride, as all of the Society does, in the completion of the second volume of The Medical History of Illinois as the proper result of the careful preservation of adequate records of the activities of the medical profession and commends this Committee for its efforts toward this end.

(DR. WHITING: I move the adoption of this portion of the report. Motion seconded by Dr. Mather Pfeiffenberger, Alton, and carried).

Medical Education and Hospitals (pp. 66-71 of Handbook): Your Reference Committee is fully cognizant of the multitude of problems in relation to the education of physicians and of trained personnel in the ancillary medical services and of the many problems of hospital activities, both staff and service. The tremendous size and complexity of the mental health problem is painfully apparent and urgently in need of positive action. This latter problem alone probably emphasizes as well as any the importance of training physicians and others to provide the necessary services outside of institutions and the importance to society of solving this problem.

We commend the Committee for the comprehensive nature of their discussion of these problems in the report as published in the Handbook.

(DR. WHITING: I move the adoption of this portion of the report. Motion seconded by Dr. W. W. Fullerton, Sparta, and carried).

Medical Benevolence (pp. 71-74 of Handbook): The report and supplementary report of this Committee emphasize the important function that it performs in taking care of our own.

Dr. Norman L. Sheehe, co-chairman, appeared before the Reference Committee and enlarged upon the use being made of the Retail Credit Company as reported in the Supplementary Report. It is the opinion of the Reference Committee that the Committee on

Medical Benevolence has carried out its functions creditably and that this has been done in the usual careful manner intended.

(DR. WHITING: I move the adoption of this portion of the report. Motion seconded by Drs. E. E. Davis, Avon, and Willis, I. Lewis, Herrin, and carried).

Medical Testimony (p. 74 of Handbook): In considering the report of the Committee, this Reference Committee agrees that the functions of a Committee on Medical Testimony are essential functions of the State Society and that every effort should be made to further these functions. Your Reference Committee feels that to be most useful the report of the Committee on Medical Testimony should outline the important aspects of its activities for the year so that the opinions and policies may be of advantage to any doctor having to perform such a service. This Committee felt that this could be done without mentioning names or places.

(DR. WHITING: I move the adoption of this portion of the report. Motion seconded by Dr. F. Lee Stone, Chicago, and carried).

Grievance Committee (pp. 74-75 of Handbook): Your Reference Committee agrees in essence with the conclusion of the report of the Grievance Committee, but it cannot help but wonder if such a small figure does truly represent the nature of the problems in our Society. Recognizing that this Committee can only function after such matters are considered on a component society level perhaps further emphasis of local committees is desirable and the stimulation of increased interest in these a valid function of the State Committee.

(DR. WHITING: I move the adoption of this portion of the report. Motion seconded by Dr. Walter E. Kittler, Rochelle, and carried).

Several resolutions have been given to the Committee.

Resolution on Post Mortem Examinations, from St. Clair County (p. 178 of Handbook): Your Committee recognizes the need for increased emphasis on autopsy examinations. We recommend the adoption of this resolution.

(DR. WHITING: I move the adoption of this portion of the report. Motion seconded by Dr. Mather Pfeiffenberger, Alton, and carried).

This Reference Committee met for a total of about nine (9) hours of which five (5) hours were spent in discussion of matters pertaining to the relations and status of the practice of optometry. Dr. Glenn H. Moore, optometrist of Chicago, attended, representing the Illinois Optometric Association and the American Optometric Association. He stated that the official interpretation of the matter considered was contrary to the interpretation of the Chicago Ophthalmological Society and that the organized optometrists were anxious to remain congenial with medicine and had no intention of encroaching upon the field of medical ophthalmology.

Drs. Mundt and Hoeltgen attended, presenting the viewpoint of ophthalmology in this controversy and emphasized that the background has been a number of years developing. It was their opinion that optometrists were entering into the field of visual care too vigorously and to the deteriment of medical eye services.

Your Reference Committee gave as much time as possible consideration of these matters and recommends adoption of Resolution #1 as follows:

Whereas, the American Optometric Association at its annual convention at Seattle, Washington, June 20-22, 1954, resolved that the field of visual care is the field of optometry and should be exclusively the field of optometry, and

Whereas, there is pending in the State of Oklahoma House Bill No. 777 and Senate Bill No. 155 giving optometrists the right to make all tests and measurements for the discovery and/or diagnosis of glaucoma and other diseases or conditions of the eye.

Therefore, be it resolved, that the Illinois State Medical Society, in the interest of public welfare, preservation of eyesight and prevention of blindness, is unalterably opposed to being excluded from the field of visual care and to granting the optometrist the right to engage in the practice of medical ophthalmology.

However, after careful consideration of all aspects of this matter this Committee felt that it did not have all of the necessary information to make specific recommendations on the other resolutions but felt that they were of such immediate importance that they should be turned over to the Council of the State Medical Society for further study and appropriate action. (Resolution No. 2, Page 196, first Session of House of Delegates; Resolution No. 3, Page 197).

(DR. WHITING: I move the adoption of this portion of the report (the referral to the Council of Resolutions Nos 2 and 3, and the adoption of No. 1). Motion seconded by Dr. J. J. Moore, Chicago)

DR. G. HENRY MUNDT, Chicago: I brought in these three resolutions. They were placed before the Eye, Ear, Nose and Throat Section of the Illinois State Medical Society, they have been passed by the Council of the Chicago Medical Society. They were passed unanimously by the Council of the Chicago Medical Society; there was one dissenting vote in the Eye, Ear, Nose of Throat Section of the Illinois State Medical Society. After the vote was taken, when I explained to the gentleman who voted against it, he said he was in error.

THE PRESIDENT: Any more discussion? The motion to refer resolutions Nos. 2 and 3 to the Council and to adopt No. 1, was carried with one dissenting vote.

DR. WHITING: I would like to make one remark. It has not anything to do with what Dr. Mundt has said. It seems to me that Dr. Mundt emphasized the great importance of this. It would be advisable in meetings like ours to have them either stenographically

reported or wire recorded. Medicine was well represented. I feel Dr. Moore who represented the optometrists, presented a very convincing argument. We recommend that this matter be re-evaluated.

(Dr. Whiting continued with the report)

There are two resolutions having to do with oral surgery (Resolution #4, page 198, 1st session of the House of Delegates, and Resolution #5, page 199, same session). Your Reference Committee considered all of the available information relative to the problem of Oral Surgery and felt that this was a matter for careful consideration on the national level and recommend the adoption of these two resolutions.

(DR. WHITING: I move the adoption of this portion of the report. Motion seconded by Dr. R. E. Heerens, Rockford and carried).

DR. MAURICE M. HOELTGEN, Chicago: I move that our delegates to the A.M.A. be instructed to vote against rescinding of the definition of oral-dental surgery brought out by the A.M.A., passed by the House of Delegates in June 1952. (Seconded by Dr. R. E. Heerens, Rockford).

DR. G. HENRY MUNDT, Chicago: Mr. President and members of the House of Delegates: I think this is a very essential thing. We have going on in a good many institutions so-called dental-oral surgery going down well into the neck. Medicine had better get on its toes and think about this. This has no relation to the efforts of dentists to get under cover of the Blue Shield. There is one thing not mentioned. I would never instruct delegates to vote any certain way.

DR. HOELTGEN: I withdraw my motion.

DR. MUNDT: Make your motion but state it carefully.

DR. HOELTGEN: I would like to reword the motion, that the House of Delegates be asked to carefully consider the rescinding of the definition of oral-dental surgery as passed by the House of Delegates in June 1952.

DR. WALTER E. KITTLER, Rochelle: I would like to make a motion that we table this motion.

THE PRESIDENT: I will ask the parliamentarian to rule.

DR. WARREN W. FUREY, Chicago: Dr. Kittler made a motion to table the previous motion. A motion to table is not debatable. (Dr. Kittler's motion seconded by Dr. Mather Pfeiffenberger, Alton).

(The motion to table was voted on and was lost).

DR. HARLAN ENGLISH, Danville: I am sure all the delegates will want to carefully study this and that we will use our judgment.

DR. PERCY E. HOPKINS, Chicago: I would make a motion that it is the sentiment of this House of Delegates that the original definition as brought in by the Board of Trustees pertaining to oral surgery be approved.

DR. HOELTGEN: I withdraw my motion.

DR. HOPKINS: It is the feeling of this assembly. It was referred to the House of Delegates in December. The House of Delegates had refused to accept the definition of oral surgery which was unacceptable to the delegates. They were willing to accept the definition of oral surgery on the basis of the A.M.A. The A.M.A. made a careful survey of the minutes and reports as to the right of the House of Delegates to attempt to go on record to define the ancillary services of medicine, such as osteopathy, chiropractics. (Motion seconded by Dr. Maurice M. Hoeltgen, Chicago).

DR. E. S. HAMILTON, Kankakee: I wish you would read what we are discussing—this definition. I am in favor of the motion that Percy Hopkins made but in justice to all of you you should know what we are voting on. This has been a very important question at national levels for a considerable period of time. I was on the committee that met with the dentists for about a year and a half. There have been many changes in it. It is a very difficult problem. Before we vote I wish you would read it.

DR. WHITING: The resolution was in the May 7th issue of the Journal of the A.M.A. The definition as presented in June, 1953, the definition of oral surgery as having to do with teeth and jaws and conditions therewith except malignancy. The definition as presented by the American Dental Association reads as follows:

(Dr. Whiting reads)

DR. G. HENRY MUNDT, Chicago: Do you think anyone in this group will be competent to make a decision after it is read? The thing that we want solved in that thing has been accomplished. I think the delegates to the A.M.A. know this thing and I believe a lot of men will go back and read it.

DR. HOPKINS: May I speak to that for a moment. It was my intention to call attention to the delegates to the A.M.A. that this House looks with favor on the definition of oral surgery as put forth by medical men in contrast to dentists. That was my entire intention.

DR. HOELTGEN: I would like to apologize to the delegates to the A.M.A. for attempted instruction. After thinking it over, that was a grave error. Secondly, I feel as Dr. Hopkins does, that we will think in terms of oral dental surgery of the effect of this particular definition, one made by medical men and second one made by dentists. In regard to the definition made by medical men you find in hospitals here in Chicago some men without an M.D. degree are doing plastic surgery of the nose and at times are going down into the mediastinum and at times are doing radical neck resections. I would like to emphasize that point for consideration of this body.

(Dr. Hopkins' motion was voted on and carried).

(Dr. Whiting continues with report).

Two other resolutions were presented to the Reference Committee, one dealing with the appropriation for tuberculosis control in the state of Illinois (See Page 4, Second Session of the House of Delegates).

It has been with amazement that the members of this Reference Committee have been following the backward steps in legislation related to the treatment of tuberculosis introduced into the 69th General Assembly. We concur in the action taken by this group of responsible authorities and recommend the adoption of their report.

(DR. WHITING: I move the adoption of this portion of the report. Motion seconded by Dr. E. S. Hamilton, Kankakee, and others, and carried).

The second resolution dealing with Civil Service status of physicians, nurses and other professional persons was presented at the second session of the House of Delegates (See page 7 of that session).

Your Reference Committee read and considered carefully the resolution dealing with the Civil Service status of physicians in public employment. No one appeared before your Committee to detail the background; however, we approved the resolution as presented.

(DR. WHITING: I move the adoption of this portion of the report. Motion seconded by Drs. R. E. Heerens, Rockford, and E. E. Davis, Avon, and carried).

DR. WHITING: I would like to take this opportunity to thank all the members of my Committee who gave unstintingly of their time in the past 48 hours to get this accomplished. We got in very little of the scientific sessions. The report is signed by Drs. Paul A. Dailey, J. O. Cletcher, H. L. Wallin, Wright Adams, and William Whiting, Chairman. I move the adoption of the report as a whole. (Motion seconded by Drs. Charles H. Phifer, Chicago, and E. H. Weld, Rockford, and carried).

THE PRESIDENT: I wish to thank Dr. Whiting and his committee for the excellent job they have done. This Reference Committee's work is an example of what we have in the state. In the city and downstate we have young men coming up whom we are sure will carry on when some of us older ones pass on.

The next report will be from Reference Committee "B", Dr. L. S. Reavley, Chairman.

Report of Reference Committee "B" on Council Committees

Advisory Committee to the United Mine Workers: This Committee has found the report of the Advisory Committee to the United Mine Workers extremely interesting and wishes to compliment the members of this Committee for their close working relationship and cogent understanding of the problems falling within its purview. The Committee believes that this report should be approved with one exception—the deletion of one sentence appearing on Page 93 of the Handbook. This sentence reads: "The Committee feels, of course, that the Welfare Fund is well within its rights in this matter as well as it is seeking only the best possible care for its recipients."

With this deletion, the Committee recommends the adoption of the report.

(DR. REAVLEY: I move the adoption of this portion of the report. Motion seconded by Dr. Earl Blair, Chicago, and carried).

Advisory Committee to Selective Service: Your Reference Committee wishes to commend the Advisory Committee to Selective Service. In discharging their responsibilities, this Advisory Committee has shown acumen and rare insight into the problems of Selective Service. The Committee should be commended for the fairness shown in the administration of the Draft Law.

Your Reference Committee recommends that this report be adopted as a whole.

(DR. REAVLEY: I move the adoption of this portion of the report. Motion seconded by Dr. E. A. Lukaszewski, Chicago, and carried).

Advisory Committee to the Woman's Auxiliary: The Advisory Committee to the Woman's Auxiliary is to be complimented for the close cooperation it has extended to the Woman's Auxiliary. Their sincerity, their many hours of working with what Auxiliary's officials in solving their problems, and their earnest endeavor to help them succeed are particularly gratifying. Their zeal in working toward this goal of a satisfactory mutual relationship in the medical world forms the base for a successful cooperation; for seeking to achieve this, the Advisory Committee to the Woman's Auxiliary is to be particularly commended.

Your Committee recommends that this report be adopted as a whole.

(DR. REAVLEY: I move the adoption of this portion of the report. Motion seconded by Dr. G. H. Edwards, Pinckneyville, and carried).

Report of the President of the Woman's Auxiliary: The report of the President of the Woman's Auxiliary to the Illinois State Medical Society, Mrs. Albert Kwedar, is illuminating and full of accomplishment. In all their activities and projects, the Woman's Auxiliary has presented public relations of the finest order. Their efforts in promoting the sale of the new volume on the Medical History of Illinois are significantly outstanding.

Your Reference Committee believes, however, that action on Resolutions No. 6, 7, and 8, calling somewhat for a reorganization (See First session of House of Delegates, pages 201-204) should be deferred.

Your Committee recommends that the Woman's Auxiliary to the Illinois State Medical Society revise its constitution and by-laws to conform with the Constitution and By-Laws of the American Medical Association's Woman's Auxiliary; the Committee further recommends that the Woman's Auxiliary to the Illinois State Medical Society take into consideration Resolu-

tions No. 6, 7, and 8 presented to the House of Delegates of the Illinois State Medical Society in this 1955 Annual Session. The Committee further recommends that the Auxiliary submit their proposed revised constitution and by-laws for approval of the Advisory Committee of the Woman's Auxiliary to the Illinois State Medical Society.

Although your Reference Committee is asking for deferred action on these three resolutions at this session, it wishes to commend those who worked so assiduously in their development.

Your Committee moves that the report of the President of the Woman's Auxiliarly be approved as a whole but recommends that action be deferred on Resolutions No. 6, 7 and 8.

DR. WHITING: I so move. Motion seconded by Dr. John W. Long, Robinson).

DR. MAURICE M. HOELTGEN, Chicago. Dr. Whiting will you read the resolve on resolution No. 6. (Dr. Whiting reads)

This particular resolution sets up a policy of branches of the county organization of the Woman's Auxiliary to the county medical societies. I think the constitution clearly defines the Woman's Auxiliary. It is set up on national level, state level and county level. In no place is there room for anything larger than the county level. In Chapter XI it states, there will be only one county charter in any one county. If a county chooses to have one or fifty branches that is its responsibility. I would prefer to have this particular resolution passed. I think it would clarify the issue of the three levels of organization of auxiliaries to medical societies.

DR. FRANK H. FOWLER, Chicago: I would like to have him define the word "defer". Defer until when?

DR. REAVLEY: The word "defer" is hard to define. We have recommended that the Auxiliary revise their constitution and by-laws to conform to the constitution and by-laws of the Auxiliary of the American Medical Association. I understand that yesterday there was a resolution presented in the House of Delegates of the Auxiliary in which they appointed a committee to revise the constitution and by-laws in accordance with this request and to report back next year.

DR. FOWLER: I would like to amend this resolution to have it acted upon by the Council of the State Medical Society. (Amendment seconded by Dr. Caesar Portes, Chicago).

DR. HOELTGEN: I would like to amend the amendment that this body approve the resolution and recommend to the Council for implementation. (Motion seconded)

DR. G. HENRY MUNDT, Chicago: There is no man in this room better acquainted with the early history of the Woman's Auxiliary in the State of Illinois than I. It went along for a long time and I think there was a very kindly feeling downstate and in the Chicago Medical Society. I can remember many years ago when we all got together for the meeting of the Illinois State Medical Society free of conflict. We finally got to the point where we had a nice system established. There has been no conflict in the county of Cook and downstate. I think it is very essential that we establish something of that kind in the Woman's Auxiliary. Dr. Reavley said he understood there was a committee appointed. I have been told that there was. That committee is entirely composed of downstate women. I do not believe that is a healthy thing. The county of Cook has an Auxiliary and I doubt whether that group should be eliminated in consideration of alterations in the by-laws and constitution.

THE PRESIDENT: Any further discussion?

DR. C. PAUL WHITE, Kewanee: I served on that committee for seven years until last year. I heard this House and the men in charge of this Society speak of the public relations value of the Woman's Auxiliary. Whether you know it or not this is a "hot potato". It affects ceratin people as to what is the proper way to carry on the activities of the Woman's Auxiliary, particularly in Cook County. Gentlemen, I think that Dr. Reavley and his Committee have done a very nice job making suggestions and side stepping. I do not believe that it is our policy to actually go down and dictate to these women. We have suggested through this Committee that they revise their constitution and I am sure that they are going to think along that line and do it. When they have done it, what more would they do? Let us as doctors stop dictating to these women who are doing such a beautiful job. Let us not disturb their relations. We do not want to do that. We simply want them to have direction on where they can make their auxiliary better and better. I have confidence in these women that they will do it better if we leave them alone, rather than through the Council. I feel that we should not pass the amendments. I think that we should help the committee. We do not have to adopt a thing as hot as this in one hour or in a few short months. Another year would be all right, and then if they cannot make out it is time for us to pass such a motion.

THE PRESIDENT: We will vote on the amendment.

DR. WARREN W. FUREY, Chicago: The original motion was to defer action. Dr. Fowler made an amendment to refer it to the Council. Dr. Hoeltgen made a second amendment that we act on the resolution and refer to the Council for implementation. He is making a recommendation which is contrary to the original motion. If you wish to act on Dr. Hoeltgen's amendment, you cannot develop the original motion by Dr. Reavley.

DR. HOELTGEN: The Advisory Committee of the Chicago Medical Society approved this report originally. It was taken to the Council of the Chicago Medical Society and the Council adopted this report unanimously. The resolution was taken before the Resolutions Committee of the Council of the Chicago Medical Society and they requested adoption. It was passed unanimously by the Council of the Chicago Medical Society. The first resolution has to do with definition of the levels of the auxiliaries. The second resolution has to do with a request for appropriate representation and fair representation. There was no attempt to request anything but a fair democratic representation. The third resolution has to do with a fair proportion of the auxiliaries of Cook County and downstate, and that that be increased. The action taken by the House of Delegates yesterday places three individuals on this committee to change the by-laws, all from one group. This is not fair representation nor is it a fair and equitable manner of doing. We in Chicago have been trying to do something about this since last fall, since September. We have gone through all the channels. I have no intention of establishing any policy recommendation in this House, only to explain these three resolutions.

THE PRESIDENT: Any further discussion on Dr. Fowler's amendment?

DR. MUNDT: As a substitute motion I move that the Committee report be changed so that the first portion can be acted upon by this House and then the three resolutions be acted upon. (Motion seconded by Dr. Caesar Portes, Chicago).

DR. WHITE: I do not feel, gentlemen, that we are approaching this right at all. With the substitute motion we are still sidestepping something. I cannot help but feel, having been approached by parties on all sides, downstate and Chicago delegations likewise to this House, that this is such a serious thing that unless we use a great deal of judgment we can break the backbone of our Auxiliary in certain places. Gentlemen, I still feel that it is not important enough for us to act immediately until these women have opportunity to do this in committee.

DR. CAESAR PORTES, Chicago: I would like to take this opportunity to express my opinion about this action and this motion. I must say that we all know the Woman's Auxiliary's job is public relations and they have done a tremendous job. They did the leg work many times for us when we needed it. We appreciate their work and we want their support. We want the Auxiliary to flourish and prosper. No one is going to break the back of the Illinois State Medical Society's Woman's Auxiliary, nor do we want the Chicago Medical Society's Auxiliary's back broken. All we ask is equal representation just as we have it in the Council of the Illinois State Medical Society. All we ask is that our women who are doing a tremendous job for us have equal representation.

DR. REAVLEY: A great many women were present the other day at our hearing. I do not care to repeat anything that was said but the majority of the women would vote that they be given time to straighten out their own affairs.

THE PRESIDENT: Is there any more discussion on the substitute motion? (The vote is taken and the substitute motion is lost).

Now we are back to Dr. Fowler's amendment to Dr. Reavley's motion. (The amendment is voted on and lost).

Now we go back to Dr. Reavley's original motion. (On vote the original motion is passed).

(Dr. Reavley continues the report)

Committee on Blood Banks: Your Reference Committee believes that the Committee on Blood Banks should be paid special tribute for its accomplishments during the past year, particularly and notably the establishment of a Clearing House among blood banks.

The Committee moves that this report be adopted as a whole.

(DR. REAVLEY: I move that this portion of the report be adopted. Motion seconded by Dr. Mather Pfeiffenberger, Alton, and others, and carried).

Committee on Cancer Control: The work of the Committee on Cancer Control is unusually significant. Special acknowledgement should be accorded to this Committee, particularly now since its activities have received national recognition.

Your Reference Committee recommends that the Committee's report be adopted as a whole.

(DR. REAVLEY: I move the adoption of this portion of the report. Motion seconded by Dr. Elmer V. McCarthy, Chicago, and carried).

Committee on Cardiovascular Disease: The Committee on Cardiovascular Disease deserves special commendation for its sagacity in facing the problems falling within this group of diseases. Special tribute is accorded this Committee for the close liaison it has maintained with the numerous agencies in the field.

Your Reference Committee moves the adoption of this report as a whole.

(DR. REAVLEY: I move the adoption of this portion of the report. Motion seconded by Dr. G. H. Edwards, Pinckneyville, and carried)

Committee on Constitution and By-Laws: The Committee on Constitution and By-Laws should be commended for its diligent alertness to needed change.

Your Reference Committee recommends that this report be adopted as a whole.

(DR. REAVLEY: I move the adoption of this portion of the report. Motion seconded by Dr. Walter E. Kittler, Rochelle, and carried).

(DR. REAVLEY: The Committee wishes to recommend that this report be adopted as a whole. Motion seconded by Dr. Tom Kirkwood, Lawrenceville, and carried).

DR. REAVLEY: This report is signed by Jean W. Moore, George E. Kirby, A. J. Linowiecki, E. A. Lukaszewski, and Lester S. Reavley, Chairman.

DR. CHARLES P. BLAIR, Monmouth: I move that this Committee be commended for the extreme amount of work done and the time they spent. (Motion seconded by Drs. Mather Pfeiffenberger, Alton, and E. E. Davis, Avon, and carried).

THE PRESIDENT: We will now hear the report of Reference Committee "D", Dr. C. Elliott Bell, Chairman.

Report of Reference Committee "D" on Council Committees

The following constitutes the report of Reference Committee "D", the members of which are C. Elliott Bell, M.D., Chairman, John E. Bohan, M.D., Andrew J. Sullivan, M.D., Walter C. Bornemeier, M.D., and John E. Wall, M.D.

Let it be known that the following recommendations have received the unanimous approval of all of its members, without exception.

We have examined the reports of six Council Committees, representing the work of 68 members who, collectively, remind us of nothing so much as an army of ants who built an ant hill on a golf tee.

Came the first bright day of spring—and the first adventurous golfer who teed up his ball, lined up his club, swiveled his shanks and swung a mighty swing—completely missing the ball, but partially demolishing the ant hill, and killing a large number of ants.

Undaunted, he reapproached the ball, lined himself up a second time, and swung with all his might—again missing the ball, but further damaging the ant hill.

At this point one of the few surviving ants said to the others, "If we stay here, we'll get killed; We better get on the ball!"

It is quite obvious to all the members of Committee "D" that these 68 tried and trusted wheel horses have been "on the ball" from the first to the last of the 365 days comprising the current year.

INDUSTRIAL HEALTH COMMITTEE—(Page 125 of Handbook): The Committee on Industrial Health met seven times in executive session and conducted a tremendous volume of business through correspondence and personal conferences.

This Committee was created primarily to formulate a program which would elevate the standards of medical care and improve the administration of workmen's compensation cases. A secondary objective is the improvement of medical relations with management, labor, the Industrial Commission and the legal profession.

The first step taken was the publication in May, 1954, of a report on the current status of "Medical Relations under the Workmen's Compensation Act in Illinois". The second step was designed to establish a foundation for correction of abuses currently too prevalent, and to provide a basis for developing a more effective program for managing occupational disability in the individual worker.

This was accomplished through a specific request for suggestions and cooperation from labor, management, the legal profession, and members of the Industrial Commission regarding medical testimony, medical reports, medical legislation, educational seminars and publications.

At the same time an attempt was made to survey current opinion within the profession of medicine throughout the state regarding the management and administration of compensation cases. In order to establish factual data, a questionnaire was mailed to every physician practicing in Illinois. While the intent behind all of the questions was most honorable and above-board, this questionnaire suffered the fate of most questionnaires—namely the inability of the designer to accurately transmit to the subject the precise meaning of each individual question.

This led to a certain amount of legible stammering, which we hope in most instances is merely a transient disorder.

The questionnaire itself dealt with the possible establishment of a registry of self-nominated doctors willing to attend compensation cases at the request of the employee, employer or the insurance carrier, or all three. It also established the willingness of the majority of physicians to submit reports within a reasonable period of time, and to accept the responsibility of consultation regarding the degree of permanent disability, etc., etc., etc.

This Reference Committee wishes to commend the members of the Committee on Industrial Health for their sincere and intelligent approach to this complex problem. We wish also to assure them of our confidence in their ability to successfully complete a job which has only just begun, and wish to recommend to the House of Delegates that the work of this Committee be continued during the coming year.

Finally we would like once more to remind the members of the House that under the current laws of this state the injured employee is deprived of his constitutional right to choose his own physician.

Mr. Chairman, we recommend the approval of this report.

(DR. BELL: I move the adoption of this portion of the report. Motion seconded by Dr. Walter C. Bornemeier, Chicago, and carried).

Liaison Committee on Medical Education—(Page 131, Handbook): Committee "D" wishes now to ask your consideration of the report submitted by the Liaison Committee on Medical Education. Officially, we wish to commend the Committee, not only for the artful manner in which their report was submitted, but also for the extremely tactful approach to the entire problem.

(Should there be any questions regarding the exact nature of this report, we will be glad to answer them at another, and more suitable time and place.)

Mr. Chairman, we move the adoption of this report.

(DR. BELL: I move the adoption of this portion of the report. Motion seconded by Dr. Walter C. Bornemeier, Chicago, and carried).

Committee on Maternal Welfare (Page 131, Handbook): We next invite your consideration of the report of that well-populated Committee on Maternal Welfare, which has now been in operation for more than 12 years, and which has during this time accumulated a reservoir of significant material, which if properly presented to the profession, could contribute to the elevation of the standards of obstetrical care provided by the physicians of this state and elsewhere.

The Committee on Maternal Welfare comes to Reference Committee "D" with a specific request that we recommend to the House of Delegates, that permission be granted for publication of the results of this accumulated experience.

Since the jurisdiction of Committee "D" terminates with the completion of this report, and since this accumulated material, like fire, can be not only a useful but also a dangerous implement, we recommend to the House that the Council establish a screening committee to which the Maternal Welfare Committee may submit not only a general plan of presentation but also each individual paper. We are of the opinion that such a screening process will be a protection, not only to the State Society and its component members, but also to those who compose the Maternal Welfare Committee itself.

Mr. Chairman, we move the adoption of this portion of the report.

(DR. BELL: I move the adoption of this portion of the report. (Motion seconded by Drs. F. Lee Stone, Chicago, John E. Bohan, Alexis, and Walter C. Bornemeier, Chicago, and carried.)

The Committee on Maternal Welfare furthermore submits a report on an exhibit shown at the annual meeting of the Illinois State Medical Society in 1954. We wish to commend the committee not only on the quality of the copy but also upon the good taste exhibited in creating the design of this exhibit. We would furthermore wish to suggest that similar exhibits be prepared at appropriate intervals to orient members of our profession, and the public, on the splendid work being done by this Committee.

This Committee also calls our attention to its extraordinary skill in the field of promotion, and documents its remarks with the fact that under their auspices, some 3,000 persons connected directly or indirectly with the practice of obstetrics and gynecology were assembled in Chicago—under one roof—in one conference for five consecutive days, each packed with the latest information which was made available for practically no effort on the part of the individual participants.

Committee "D" wishes to commend the Maternal Welfare Committee on these accomplishments.

Mr. Chairman, we move the adoption of this portion of the report.

(DR. BELL: I move the adoption of this portion of the report. Motion seconded by Drs. David Freeman, Moline, and F. Lee Stone, Chicago, and carried).

Finally comes the request for approval of the creation of yet another *"Illinois State Maternal Welfare Committee"* in addition to the current *"Committee on Maternal Welfare"* which has already been in existence for the past 12 years. This new organization would be composed of 13 sectors of American society having some interest in the training of professional personnel and in the practice of obstetrics. A goodly number of the participating groups would be composed of non-professional persons such as administrators of maternity homes, non-professional members of Public Health Departments, administrators and board members of hospitals, etc.

After a careful consideration of the accomplishments of the current Committee on Maternal Welfare, supported by their own statement of the tremendous progress brought about through their own efforts, Committee "D" is convinced it would be hard to improve upon this record and therefore we can little or no need for altering the structure of this organization. We wish to make the additional comment that we would consider it an administrative blunder to share the credit for the exceptional accomplishments of this Committee with other groups who will have in no way contributed to its success. Furthermore, we are of the opinion that the best interests of medicine will be served by keeping complete control of the practice of obstetrics within the jurisdiction of the Illinois State Medical Society.

We, therefore, recommend that this portion of the report be not adopted.

(DR. BELL: I move that this portion of the report be not adopted. Motion seconded by Dr. F. Lee Stone, Chicago).

DR. WALTER C. BORNEMEIER, Chicago: I am a member of the Reference Committee. I would like to speak to this. If you turn to page 133, it says . . . . . "postgraduate studies could be arranged for nurses, doctors, public health officers who could come together for an annual congress." We do not mind if they do that in an advisory capacity but if they are going to establish a new organization, I agree with the Committee's report that this portion of the report should not be adopted.

DR. EDWIN S. HAMILTON, Kankakee: I would last paragraph of the report re-read. (Dr. Bell read this portion)

DR. HAMILTON: I would move that that last sentence be deleted. That would be poor public relations. I move this as an amendment. (Dr. Walter C. Bornemeier, Chicago, seconded the amendment).

(The amendment was voted on and carried, then the original motion as amended was carried).

Medical Economics (Page 136, Handbook): Committee "D" next wishes to present the report of the Committee on Medical Economics. We are of the unanimous opinion that this Committee has discharged its assigned duties with distinction. The excellent articles contributed to the Journal by its members have disclosed a wealth of editorial ability heretofore unsuspected in members of the Illinois State Medical Society.

During the discussion of this report, a number of additional subjects have been suggested for development in the future.

We recommend, therefore, that this Committee be continued throughout the coming year.

Mr. Chairman, we recommend adoption of this report.

(DR. BELL: I move the adoption of this report as submitted. Motion seconded by Dr. John E. Bohan, Alexis, and carried).

Medical History (Page 137, Handbook): We now ask your consideration of the report of the Committee on Medical History. We have nothing but praise for the tremendous amount of work done by this Committee. The Second Volume of the History of Medical Practice in Illinois has been completed, and is now available to the profession and to the public for the sum of ten dollars ($10.00). We suggest that the House give this Committee a standing vote of thanks for a big job well done.

We also recommend that every physician in this state avail himself of a copy, especially those who belong to the so-called younger generation.

Nowhere in the annals of medicine can one find a better description of the problems which medicine has faced in the past.

The younger practitioner will discover that our *current* problems are simply *old* problem *reactivated.*

Nowhere will he learn so well of the Halycian, or golden era of medicine. Nowhere else will he be able to trace the loss of public favor which resulted from the cool scientific era which followed. Nowhere else will he become so well aware of the current Herculean, or heroic, era which is now in its beginning—that era in which a few courageous physicians are attempting once more to introduce the humanities into the scientific practice.

Nowhere else will he see so clearly the truth of that immortal statement made by Edmund Burke, "Nothing contributes to the triumph of evil so much as the fact that good men do nothing".

We would urge every doctor to appoint himself as a salesman and promoter so that we may place this work in the hands of as many people as possible, and into as many institutions, schools and libraries as can be sold on its value as a superior example of historical and literary achievement.

Mr. Chairman, we move the adoption of this request.

(DR. BELL: I move the adoption of this portion of the report. Motions seconded by Drs. E. S. Hamilton, Kankakee, and F. Lee Stone, Chicago, and carried).

DR. BELL: We would like to have Dr. James H. Hutton and Dr. Tom Kirkwood stand up and take a bow for a good job well done.

Mental Health (Page 140, Handbook): We now wish to present the report of the Committee on Mental Health. This Committee has conducted its affairs with superlative skill. During the process of appraising this report we have discovered an extraordinary insight into the problems, visible and invisible, written and unwritten, which the profession must face today. We are individually anud collectively convinced that the men who direct the activities of this group are doing their utmost to safeguard the interests not only of the individual patient suffering from mental illness, but also of every individual physician now practicing in this state.

Mr. Chairman, we approve the adoption of this report.

(DR. BELL: I move the adoption of this portion of the report. Motion seconded by Dr. J. J. Moore, Chicago, and carried).

Committee "D" has received the resolution introduced by Dr. Albyn Wolfe, Jacksonville, introduced at the second session of the House (See Page 6, Second Session), reviewed it and recommends its adoption.

(DR. BELL: I move the adoption of this resolution. Motion seconded by Dr. S. M. Goldberger, Chicago).

DR. HARRY MANTZ, Alton: I do not know quite what I want to say. I have been thinking about it ever since it was introduced yesterday. Certainly we have to see where we can begin. No one here, I am sure, does not agree that these centers are a necessity. I want to know why the state must run them. If I were a pediatrician I would be ashamed to come before this House of Delegates to ask the state to take over a function which we should do for ourselves. Hence, the next step is moving in on us without our asking them to do it again. I certainly think the pediatricians should think a long time before they come to us and ask us to go to the state to get them money for a function which medicine should take over itself without referring to the state. I would like to hear some discussion on this, if we want these premature centers continued until such a time as medical service can take it over as a private endeavor. I do not think this House of Delegates or any other House of Delegates should make a practice of asking the state for funds for things we should do ourselves.

DR. G. H. EDWARDS, Pinckneyville: I have been aware of this service being available for five years and on only one occasion was it used. In my community it is not popular.

DR. JOSEPH T. O'NEILL, Ottawa: Mr. President and Members of the House: In defense of the pediatricians something should be said. The care of premature infants is a particularly specialized field of pediatrics. I think every pediatrician is qualified to take care of a premature baby but every hospital is not equipped to take care of them. In small hospitals down state where 200 to 300 deliveries are accomplished every year with a small percentage of premature deliveries. In order to set up a center to take care of them, you have to have special personnel and special nursery. These people qualified as special personnel in nursing are not to be had. Consequently, in small areas of the state it has been necessary to set up these centers. We deplore them, but it is a matter of saving lives of these children. The Maternal Welfare Committee will give you figures as to the lowered mortality in women where these centers have been set up. If the time ever comes when we have adequate facilities and adequate funds in these small hospitals we shall be more than glad to take care of them.

DR. WALTER C. BORNEMEIER, Chicago: I agree with Dr. Mantz. The Committee felt that as the Pediatric Society was sponsoring this resolution we should pass it.

DR. MANTZ: I did not mean that we do not approve of this. What I meant to bring out was that we should not go back every year for funds. Give them money this year but let us get something more permanent.

DR. WILLIAM WHITING, Dongola: In my experience in our hospital where there are about 425 deliveries, most of our premature deliveries occurred in women who were in a difficult financial state, and though I am in favor of Dr. Mantz' suggestions, a premature center is necessary because it takes care of people who are not able to take care of themselves. They would not be adequately cared for unless those centers were available.

DR. BELL: You can see the magnitude of these centers. If we take them over we are accepting quite a job.

DR. JOHN R. WOLFF, Chicago: The care of premature babies is purely a local problem in most communities. I think it would be well that since most of these communities need help, to pass the resolution but to ask the Maternal Welfare Committee to study the problem and come in next year with another resolution.

DR. O'NEILL: The point brought up by Dr. Wolff is very succinct. I assure you it will be the duty of the Council to instruct the Maternal Welfare Committee this year to make a study of this subject and to bring in a report to the House of Delegates next year.

THE PRESIDENT: Any further discussion? (The motion to adopt the resolution was carried with one dissenting vote).

(Dr. Bell continuing)

In conclusion, the Chairman of Committee "D", in making his *first* appearance at the rostrum of this august body, wishes to state that he feels somewhat like the dog fancier's year-old son. When a friend of the family asked, "Can the lad talk yet?" the dog-fancier replied, "No, but he is learning to bark."

(DR. BELL: Mr. Chairman, I would like to move the acceptance of this report as a whole as amended. Motion seconded by Dr. J. Ernest Breed, Chicago, and carried).

The report is signed by Drs. Walter C. Bornemeier, Andrew J. Sullivan, John C. Wall, John E. Bohan, and C. Elliott Bell, Chairman.

DR. PRESIDENT: We will now hear the report of Reference Committee "E", Dr. John R. Wolff, Chairman.

Report of Reference Committee "E" on Council Committees

Military Affairs and Emergency Medical Service—Civil Defense: The Committee has presented us with a short summary of their work. We should like to emphasize to you that the Committee has been exceedingly active and industrious in their efforts to prepare the citizens of Illinois to be ready for attack in these days of atomic weapons. The Chairman, Dr. Earl H. Blair, is to be commended, as is the entire Committee, for their continuing energy in our behalf. They have been alert to our present and future dangers which might involve our cities and their local communities.

Let us all praise the Committee for their thinking and hope that their entire efforts shall truly be in vain; let us pray for a peaceful world.

In the meantime, we commend this Committee for their continued alertness and attention to this ever present danger.

The Committee recommends that this report be adopted.

(DR. WOLFF: I move the adoption of this portion of the report. Motion seconded by Dr. Charles P. Eck, Chicago, and W. H. Newcomb, Jacksonville, and carried).

Necrology: The cooperation of the Secretary's Office and the Committee on Necrology furnishes the Society with an unpleasant but necessary awareness of the members who have died. The names appear on Page 144 of the Handbook. Both groups are to be thanked for their efforts for the past year in recording these sad changes.

Your Reference Committee recommends the adoption of this report.

(DR. WOLFF: I move the adoption of this portion of the report. Motion seocnded by Drs. E. A. Lukaszewski, Chicago, and F. Lee Stone, Chicago, and carried).

Nutrition: The Committee on Nutrition has been exceedingly active concerning the subject that is fundamental to the health and welfare of our community. The word "nutrition" often leads to misunderstanding thoughts concerning fads, reducing diets and infant feeding. The Committee is concerned with not only what is good nutrition but how we can improve the quality of food from an agricultural standpoint as well as the medical use and knowledge we now have on this subject. They have worked with the Friends of the Land to a great extent to increase our knowledge on these subjects. With this in mind a program has been planned for the fourteenth Annual Institute on Soil, Food, Health Relationships, June 27-29, 1955, in Chicago. Dr. Paul A. Dailey, Chairman of the Committee, will be glad to acquaint you with this program and, it is hoped, that you will send representatives from your local districts to this meeting so that your community can be informed of the many advances on this subject. The Committee is doing a fine job and we hope that they will continue their good efforts in the future.

Your Committee recommends the adoption of this report.

(DR. WOLFF: I move the adoption of this portion of the report. Motion seconded by Dr. Charles P. Eck, Chicago, and carried).

Nursing: In the consideration of the report on the Committee on Nursing, we should like to include our report on the three resolutions presented to the Committee concerning the nursing problems in Illinois. The resolution entitled "Student Nurses Training" from the Champaign County Medical Society is presented on Page 177 of the Handbook. Resolutions from the Ford County Medical Society and the Edgar County Medical Society both ask for approval of the Champaign County Medical Society's resolution.

Your Reference Committee was pleased to have a great many people attend the meeting to discuss the resolution by the Champaign County Medical Society. We are thankful to the Champaign Society for their interest in this problem. We are also thankful to have James Gersonde, Secretary of the Illinois Hospital Association, hospital superintendents from the Champaign and Springfield areas, and many members of the Council of the Illinois State Medical Society in attendance. The discussion was quite illuminating and significant.

Your Illinois State Medical Society has long been cognizant of the effect of recent regulations on the student training program in Illinois. Last year, Dr. Joseph T. O'Neill in his report as Councilor of the Second District, emphasized the need of action by this Society. At our meeting last year, a resolution was passed covering the regrettable state of the training schools in the smaller hospitals throughout the state. In October, 1954, Dr. Roland Cross, Jr., wrote an illuminating editorial comment of this subject in the Medical Economics Section of the Illinois Medical Journal.

Today we not only have resolutions on this subject but a grass root demand for action.

Your Reference Committee feels that it is deplorable that with the great need for nurses so many hospitals have been forced to close their training schools. Where are our local communities to obtain their nurses?

This is a compelling problem. Therefore, your Reference, Committee is greatly in accord with the resolutions as presented.

We have modified the wording of the Champaign County Medical Society in a few instances. The resolution now reads:

Whereas, a continuing supply of trained nurses is an absolute requisite to the operation of community hospitals, and

Whereas, many hospitals in the State of Illinois, have had to stop the education of trained nurses for various reasons, and

Whereas, a most important cause of nursing school closure is the unrealistic, arbitrary, and constantly changing rules and regulations promulgated by the Department of Registration and Education in the State of Illinois, and

Whereas, a continuing pattern of arbitrary regulations without regard to the elemental community needs in our great state can only result in fewer and fewer of our young women becoming nurses,

Therefore be it resolved, that the Illinois State Medical Society and its members encourage Community Hospital Schools of Nursing to increase their efforts at educating young women for nursing in any reasonable manner which is in the best interest in the care of the patient and local community betterment, and without lowering present academic requirements, and

Further be it resolevd, that the Illinois State Medical Society request the Governor of the State of Illinois to appoint a separate Commission composed of practicing physicians, nurses, hospital administrators, and educators to regulate schools of nursing and to develop such a program.

We not only move for the adoption of this report and the approval of the resolutions but we should like to add that now, and I mean now, is the time for action.

We hope that the Council and the Officers of the Illinois State Medical Society will give their immediate attention and their energy to this problem.

We urge the adoption of this report with the modifications contained in the resolution.

(DR. WOLFF: I move the adoption of this portion of the report. Motion seconded by Dr. E. A. Lukaszewski, Chicago, and carried).

Physical Medicine and Rehabilitation: The Committee on Physical Medicine and Rehabilitation is doing an excellent job. There are many questions concerning the rehabilitation program and the various rehabilitation clinics that have been set up throughout the state. You should feel free to send your problems to this Committee for their opinions.

We move the adoption of this report.

DR. WOLFF: I move the adoption of this portion of the report. Motion seconded by Dr. Charles P. Eck, Chicago, and carried).

Committee on Postgraduate Education: Dr. Louis R. Limarzi, Chairman of the Committee on Postgraduate Education, and his members are doing a wonderful piece of work. The meetings which they have arranged have been well attended and stimulating from the scientific standpoint. It is hoped that the Councilors and Secretaries of the local medical societies will feel free to work with Dr. Limarzi and his Committee so that not only will this program be continued, but that it will also continue to flourish.

Your Committee moves the adoption of this report.

(DR.WOLFF: I move the adoption of this portion of the report. Motions seconded by Drs. E. A. Lukaszewski, Chicago, and D. B. Freeman, Moline, and carried).

Resolution Re Educational Fund: (See Page 186, First Session of the House). The resolution submitted by the Jefferson-Hamilton County Medical Society, discussing the allocation of membership dues to the American Medical Education Foundation, was carefully considered.

Your Reference Committee was not in agreement withthe tought expressed in this resolution. We feel that the twenty dollars ($20.00) which we pay to the American Medical Education Fund through our dues is little enough to give for the education of future physicians. The Illinois State Medical should continue its leadership in the collection of funds for this worthy purpose.

Your Reference Committee, therefore, recommends that this resolution be not adopted.

(DR. WOLFF: I move the adoption of this portion of the report, that this resolution be not adopted. Motion seconded by Dr. E. E. Davis, Avon, and carried).

The report is signed by Drs. James H. Hutton, Fred A. Tworoger, Russell Jensen, David B. Freeman, and John R. Wolff, Chairman.

I wish to thank the members of the Committee for the opportunity of working with them. (I move the adoption of the report as a whole. Motion seconded by Drs. E. A. Lukaszewski, Chicago, and W. W. Fullerton, Sparta, and carried).

THE PRESIDENT: We will now have the report of the Reference Committee on Miscellaneous Business, Dr. A. J. Mauzey, Chairman.

Report of Reference Committee on Miscellaneous Business

1. *Committee on Rural Medical Service*: Your Reference Committee accepts the report of the Rural Medical Service in full with a vote of confidence and commendation for the excellent work accomplished during the past year.

Special attention is directed to the following facts:

(a) Some 80 students to date have been recipients of financial assistance of the Farmer-Doctor Loan Fund. About 10 men enter practice yearly in Illinois as a result of this aid.

(b) It is to be emphasized that the Rural Medical Service has been possible without any expense to the Illinois State Medical Society.

(c) Additional attention is invited to the great value of the Health Improvement Associations. Over five million dollars worth of service has been paid for through the Health Improvement Association movement to improve hospital and medical service to individual rural families. It is expected that during the next two years 80% of all rural families will benefit by this program.

It should also be stressed that scholarships for nurses are now available through the Health Improvement Association.

(DR. MAUZEY: I move the adoption of this portion of the report. Motion seconded by Dr. Elmer V. McCarthy, Chicago, and carried).

2. *Committee on Scientific Service*: Your Reference Committee recommends a vote of commendation for the fine work the Scientific Service Committee has done in spite of difficulties encountered and accepts the report in full.

Your Reference Committee especially recommends that each component county organization have an assistant program chairman who may act as chairman the following year. It is also felt that the members of the component societies should cooperate more with the program chairman in selecting future programs. The Committee recommends that adequate notice be given the Scientific Service Committee, preferably a year outlined in advance, regarding the programs and speakers desired by component county societies.

(DR. MAUZEY: I move the adoption of this portion of the report. Motion seconded by Drs. E. A. Lukaszewski, Chicago, and E. V. McCarthy, Chicago, and carried).

3. *Committee on Tuberculosis Control*: Your Reference Committee recommends that the Committee on Tuberculosis Control be commended for the fine work it has done.

A. There are fewer patients in tuberculosis hospitals and less tuberculosis in the state, no doubt due in some part to the efforts of the committee.

B. The Committee on Tuberculosis Control has made the following specific recommendations, which this Reference Committee approves:

1. That the Illinois State Medical Society endorse the principle of mass x-ray survey and encourage the continued use of this method throughout the 101 counties in the state and the metropolitan area of Chicago.

2. That the Illinois State Medical Society endorse in principle a law to require an initial employment chest x-ray of all employees of public and private schools in the state of Illinois, with provisions for an annual x-ray of all such employees.

3. That the Illinois State Medical Society endorse the principle of the five-man board for the Chicago Municipal Sanitarium.

4. That the State Health Department be requested to set up a limited number of security beds in the two State Tuberculosis Hospitals.

5. That the House of Delegates endorse the principle of routine x-rays for all hospital admissions in the state of Illinois, that all members of the Illinois State Medical Society use their influence to set up such provisions in their own individual hospitals. And that where such provisions are not available the House of Delegates should recommend that the members of the Society order routine chest x-rays on all their patients whose illness requires hospitalization.

6. A request for an increase of funds for the purpose of tuberculosis survey and control, primarily in the Chicago area.

7. The defeat of House Bill #582.

8. The defeat of the Broyle's Senate Bill #338.

Your Reference Committee wishes to emphasize that portion of the report which deals with the initial hospitalization of tuberculosis patients. Microbial therapy does not obviate the necessity of initial hospitalization of tuberculosis patients. The Committee also stresses the importance of a careful follow-up by the family physician in cooperation with the chest consultant, after release from the hospital.

(DR. MAUZEY: I move the adoption of this portion of the report. Motion seconded by Dr. Harry Mantz, Alton, and carried).

4. *Committee on Voluntary Prepayment Plans for Medical and Surgical Care*: Your Reference Committee accepts in full the recommendations of the Committee on Voluntary Prepayment Plans for Medical and Surgical Care and highly commends it on the thorough appraisal of the present progress of this important phase of medical practice.

(DR. MAUZEY: I move the adoption of this portion of the report. Motion seconded by Dr. J. Ernest Breed, Chicago, and carried).

5. *Committee on Scientific Work*: Your Reference Committee wishes to commend highly the Committee on Scientific Work for their efforts in planning the program for this annual meeting. We should like to stress the apparent value of the various section meetings as evidenced by the very good attendance at most sessions.

We should also like to advise the continuance of the use of local doctors or specialists as participants in the program, feeling that this is a great factor in promoting better attendance from all parts of the State.

Impersonal interviews with great numbers of men representing exhibitors and scientific exhibits revealed no cases of dissatisfaction in contrast to former years.

Your Committee also wishes to direct attention to the fine cooperation which the Sherman Hotel management has displayed in accommodating the various scientific displays, exhibitors and members of the Illinois State Medical Society.

(DR. MAUZEY: I move the adoption of this portion of the report. Motion seconded by Drs. Willis I. Lewis, Herrin, and J. Ernest Breed, Chicago, and carried).

Three resolutions were presented to the Committee. Your Reference Committee recommends that the resolution submitted by the Chicago Medical Society (Resolution #9, submitted at first session of the House of Delegates,) be adopted.

1. A subcommittee be created to work on a relative value scale such as that produced by the thoracic surgeons. This scale, based on points and not dollars, would apply to the whole of the practice of medicine and surgery. It would indicate the proper relation between fees for various medical and surgical specialties.

2. A program of public education by the A.M.A. Department of Public Relations on the value of a diagnostic and medical work be fostered to increase the public's appreciation of non-surgical work.

3. The American Medical Association encourages the various specialty boards in medicine to reappraise the value of their regulations restricting the practice of those seeking or holding board certificates.

4. The American Medical Association continue to discourage arbitrary restrictions by hospitals against general practitioners, and be it further resolved, that after approval by the House of Delegates of the Illinois State Medical Society, this resolution be forwarded to the House of Delegates of the American Medical Association.

Part 2: That the Illinois State Medical Society urge the House of Delegates of the American Medical Association to ask the Trustees of Hospitals to refrain from demanding that Medical Staff members submit to an audit of their books for the purpose of detecting fee-splitting and that the Hospital Association be given assurances that organized medicine is ready, willing, and able to satisfactorily solve its own problems.

DR. PERCY E. HOPKINS, Chicago: It might not be entirely clear as to the intent of this resolution or the reason for its having been initiated in the Chicago Medical Society. In West Virgina there has been a definite proposal made on the part of one organization asking for preferential treatment as far as fees are concerned for members belonging to a certain organization. That will be reported on at Atlantic City. Secondly, apparently a plan of insurance may be forced on other insurance plans. It was felt that the physicians of Illinois should have something to say concerning the plan under which they wish to work. There is an effort to crystallize the opinion of physicians of Illinois so that the delegates will have the crystallized opinion of this House of Delegates on how to act.

(DR. MAUZEY: I move the adoption of this portion of the report. Motion seconded by Dr. George Kirby, Spring Valley). Motion carried.

Your Reference Committee recommends the approval of the resolution submitted by the Macon County Medical Society (See Page 187, first Sessions of the House).

(DR. MAUZEY: I move the adoption of this resolution Motion seconded by Dr. G. H. Edwards, Pinckneyville, and carried).

DR. MAUZEY: This is my first experience. I would like to say that this experience was stimulating and understanding. The report is signed by Drs. V. B. Adams, Harry Mantz, Caesar Portes, S. M. Goldberger, Gilbert Towle, and Armand J. Mauzey, Chairman. I move the adoption of the report as a whole. (Motion seconded by Dr. Charles P. Eck, Chicago, and carried).

THE PRESIDENT: I want to thank all Committee Chairman and members.

We now come to unfinished business. I recognize Dr. James H. Hutton.

DR. HUTTON: On behalf of the Committee on Medical History, I wish to thank Dr. Moore and Dr. Kirkwood, and I want to thank Dr. Bell and his Committee for the kindly way in which the report was edited. He added something that we had not put in, to ask the support of the House of Delegates in the sale of the book. The book is out. If we sell 1,000 at $10.00 each that will be $10,000 which will just meet the cost of producing the book. If we sell 3,000 we will make some money. I hope every member of the House of Delegates will constitute himself a salesman, and also will read the book himself. If you have time only to read two chapters you will be repaid, one is the tribute to Dr. D. J. Davis written by Jim Leary and the other is the chapter written Mrs. Frances Zimmer. The Chapter by Dr. Kampmeier of the University of Illinois is very interesting.

THE PRESIDENT: Thank you very much Dr. Hutton. Is there any other unfinished business?

DR. PERCY E. HOPKINS, Chicago: I would like to call to your attention the fact that yesterday there were introduced in the Senate two new osteopathic bills, #709 and 710. They were introduced by Traeger of Peoria and Libernati of Chicago. In essence they ask for permission to do minor surgery, and that they be permitted to take the regular examinations. If you do not use the plan proposed by the Committee that is all right, but we ask you to contact your Senators.

I would also like to take advantage of the opportunity to call to the attention of the House that John Mirt since Mr. Leary's death has been doing a lot of leg work. He has provided press releases and you will agree with me that he has done a very good job and he should be thanked for it.

THE PRESIDENT: We thank Mr. Mirt for the nice work he has done. We now come to new business.

THE SECRETARY: Each year we ask permission to thank the officals of the Hotel Sherman and all the people who have cooperated to make this an unusually fine meeting. I understand we had more members at this meeting than for several years. We will compile a list. The Chairman of the Committee on Arrangements and other committees deserve a great deal of attention. One committee was especially helpful, namely Dr. Coye Mason's Committee on Scientific Exhibits. We would like the privilege of officially thanking them.

DR. E. S. HAMILTON, Kankakee: I so move. (Motion seconded by Dr. W. W. Fullerton, Sparta, and carried).

THE SECRETARY: In regard to the matter Dr. Hutton discussed, the volume 1850-1900, we will have the books at the Monmouth office and we will send them out as ordered.

There is one matter that is not on the agenda and I am sure the gentleman on the right does not know it. Kelly has done a mighty fine job this last year. He has devoted time and energy to his office. Many times he would fly down to a post-graduate conference. I wonder if the House would like to give a rising vote of thanks to our retiring President. (Rising vote of thanks given)

DR. R. E. HEERENS, Rockford: I would like to announce that through the endeavors of Dr. Weld we have a library in the Winnebago County Medical Society of 30,000 volumes. It is opened from 11 to 2 daily, and all members of the State Society are invited to visit it.

THE PRESIDENT: Now comes a most pleasant duty. I want to thank you again all your members of the Illinois State Medical Society, the House of Delegates, the officers, the Secretary, because without your help it would have been much harder to conduct this office. It has been a very pleasant year, one of friendliness. It is one of the things I will always remember and cherish. Again I want to thank you for your very fine cooperation.

I do not think it is necessary to introduce the incoming President, you all know him. At this I want to present to my successor, Dr. F. Garm Norbury, this badge of office and the gavel of the Society.

DR. F. GARM NORBURY: Dr. Vaughn, Members of the House of Delegates, Friends: If my digestion and my legs stand up a year from now as well as Kelly Vaughn's have I shall be satisfied. If I can do anywhere near as good a job as he has done for the Illinois State Medical Society, for its Component County societies, and for individual members I hope you will be satisfied. All I can say at this time is that I am deeply appreciative of the honor and that I also recognize the responsibility of the office that has been given me. I promise you that I shall work at the job.

I believe in the private practice of medicine, recognizing that by force of circumstances over which we have no control there are many outside pressures. However, the dignity of man as an individual, the dignity of our honored profession, which over the centuries has put service above self, is the thing we must maintain. As we take care of our patients, as we accept community, state and national responsibilities, thus do we show ourselves in our true light. Our patients, our confreres, our job and will support us. True we need to see that these others know that we are doing this but our own individual actions will, in my personal opinion, count for more in this respect.

I have one request to make. If any of you do me the honor of inviting me to meet and eat with your societies please don't give me onions, cabbage or Brussels sprouts. I had too many of these in Great Britain in World War II before going to France and Germany. German turnips are off the list too.

I hope I can conduct next year's session of the House of Delegates in the manner my eminent predecessor has handled this one. My thanks and best wishes to you all.

Before closing this meeting, I wish to officially introduce our President-elect, Dr. F. Lee Stone.

DR. STONE: All I can say is that I thank you and all for this high honor. Thank you very much.

The session adjourned sine die on motion duly made and seconded, at 12:18 P.M.

‹‹‹ ›››



PORTRAIT OF A DELINQUENT APPETITE...

When the clinical picture is composed of a child who "just won't eat" and a mother distraught by nervous worry and despair, prescribe

TROPHITE®

to stimulate appetite and promote growth

Each tablet or teaspoonful (5 cc.) of 'Trophite' supplies: 25 mcg. B_{12}, 10 mg. B_1

Smith, Kline & French Laboratories, Philadelphia 1

BOOK REVIEWS

HANDBOOK OF TREATMENT by Harold Thomas Hyman, M. D. Author Of Integrated Practice of Medicine Handbook of Differential Diagnosis. Published by J. B. Lippincott Company Philadelphia and Montreal.

Copyright 1955 Price $8.00

Here is a book which is intended for general practitioners as a convenient and realistic solution to the numerous medical problems which may suddenly arise in private or institutional practice.

It is unique in its arrangement for ready reference. It opens with a table of contents which is alphabetized in general according to subjective complaints, objective findings or diagnostic entities. Of necessity these have been highly selective but appear to be practical and efficient. At the end of the text is a complete index.

The individual subject headings are introduced with a statement of general principles which includes etiology, pathogenesis, pathology, diagnosis, and therapy.

In the next paragraph are given specific details of:

1. IMMEDIATE CARE: This is a summary of routine initial treatment. Subsequent paragraphs are in sequence.
2. CONTINUING CARE: (Favorable course) This details satisfactory outcome of successful treatment.
3. CONTINUING CARE: (Unfavorable course) Here a re-evaluation of the diagnosis and treatment must be undertaken and a fresh approach to the problem attempted.
4. CONTINUING CARE: (Progressively unfavorable) Here the authors makes new suggestions for medicine, or when indicated referral to an appropriate specialist.

‹ ›

SPORTS INJURIES. Edited by Christopher Woodard Honorary, Consultant to British Olympic Teams 1948 & 1952. First published 1954 Max Parrish and Co. Ltd., 55 Queen Anne Street London Wl. Published by William Clowes and Sons, Ltd., London and Beccles.

Copyright 1954 Price $3.00

This excellent monograph on sport injuries is primarily designed for coaches, athletic trainers, and teachers of physical education. The author very carefully points out that this text has not been written for the physician.

However, as many physicians are involved with high school and college athletes, it would be a valuable adjunct to their libraries.

Routine treatment for the more commonly encountered athletic injuries are included. The author has also judiciously attempted to impress upon the reader those injuries which immediately require a physician's care.

However, the main theme of the book is the active treatment of most athletic injuries. This is in rather startling variance with the more common passive forms of medicine such as strapping, massage and diathermy.

‹ ›

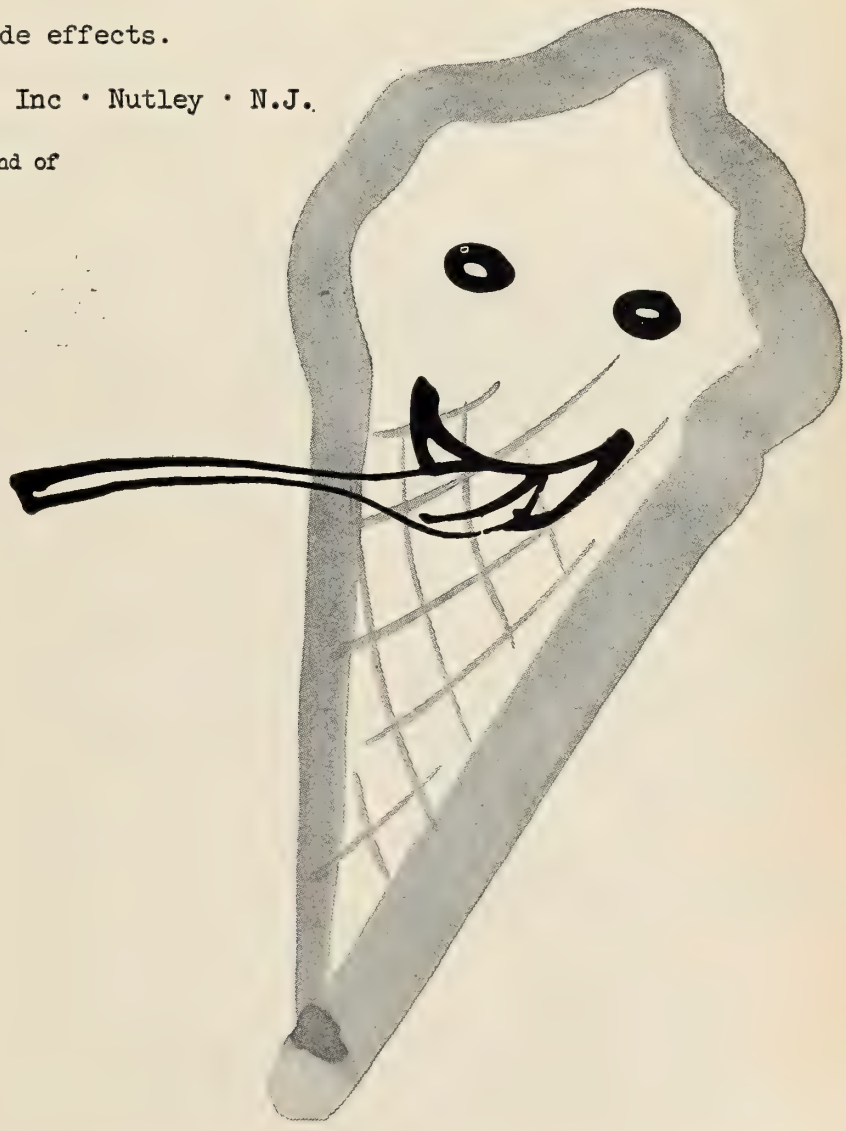
HANDBOOK OF PEDIATRICS by Henry K. Silver, M. D. Associate Professor of Pediatrics, Yale University School Of Medicine, New Haven, Connecticut; C. Henry Kempe, M. D. Assistant Professor of Pediatrics, University

(*Continued on page* 44)

Taste is as important to the young patient as effectiveness is to you. In antibacterial therapy Gantrisin (acetyl) Pediatric Suspension is useful on both counts because of its delicious raspberry flavor without "medicine" aftertaste, its wide antibacterial spectrum and notable freedom from gastro-intestinal upsets and other side effects.

Hoffmann - La Roche Inc · Nutley · N.J.

Gantrisin® acetyl -- brand of acetyl sulfisoxazole



BOOK REVIEWS (Continued)

of California School of Medicine, San Francisco, California; Henry B. Bruyn, M. D. Assistant Professor of Pediatrics and Medicine, University Of California School of Medicine, San Francisco, California, and Assistant Clinical Professor of Pediatrics, Stanford University Medical School, San Francisco, California. Published by Lange Medical Publications Los Altos, California.

Copyright 1955

This is another of those valuable ready desk reference booklets with which Dr. Jack D. Lange has been associated. The first book in this series and perhaps the best known is the "Physicians' Handbook". In the 31 chapters are covered almost the entire field of pediatrics.

Naturally this material has been greatly condensed, but not at the expense of accuracy. The charts, diagrams, and dosage schedules for drugs and fluids are particularly useful. In fact the more this little book is used on a day to day basis, the more valuable it will become.

EARLY CARE OF ACUTE SOFT TISSUE INJURIES by Committee on Trauma First Edition — 1954 Published by American College of Surgeons, Chicago, Illinois.

Copyright 1954

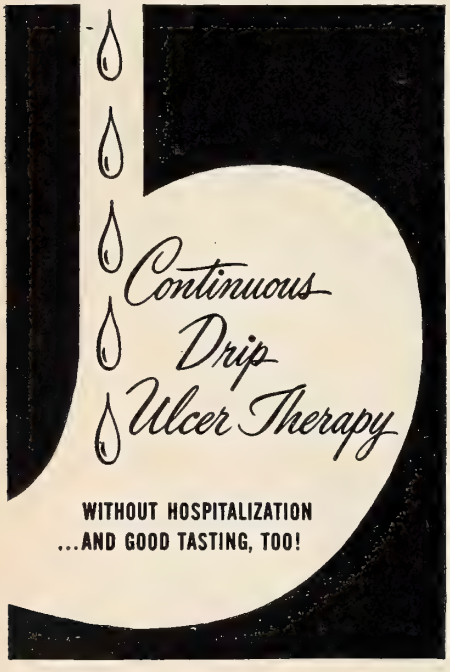
This book is a splendid companion piece to An Outline of the Treatment of Fractures published by the American College of Surgeons.

The material has been well organized and ably presented by a group of outstanding surgeons.

The chapter on burns is particularly concise and valuable. However, the derogatory discussion of the "exposure" method of treatment that "its use is not possible on an encircling burn of the extremities or the trunk" is at variance with the experience of Capt. Enyart and his group during the U.S.S. Bennington diaster.

A. M. A. FUNDAMENTALS OF ANESTHESIA. Prepared under the Editorial Direction of the Consultant Committee for Revision of Fundamentals of Anesthesia, a publication

(*Continued on page 48*)



HORLICKS CORPORATION
Pharmaceutical Division
RACINE, WISCONSIN

Nulacin

A recent clinical study* of 46 ambulatory nonhospital patients treated with Nulacin† and followed up to 15 months describes the value of ambulatory continuous drip therapy by this method. Total relief of symptoms was afforded to 44 of 46 patients with duodenal ulcer, gastric ulcer and hypertrophic gastritis.

The delicately flavored tablets dissolve slowly in the mouth (not to be chewed or swallowed). They are not noticeable and do not interfere with speech.

Nulacin tablets are supplied in tubes of 25 at all pharmacies. Physicians are invited to send for reprints and clinical sample.

*Steigmann, F., and Goldberg, E.: Ambulatory Continuous Drip Method in the Treatment of Peptic Ulcer, Am. J. Digest. Dis. 22:67 (Mar.) 1955.

†Mg trisilicate 3.5 gr.; Ca carbonate 2.0 gr.; Mg oxide 2.0 gr.; Mg carbonate 0.5 gr.



READING TIME—1 MINUTE

A FEW FACTS FOR THE BUSY DOCTOR WHO WANTS THE

Latest Information About Filter Tip Cigarettes

Your patients are interested in cigarettes! From the large volume of writing on this subject, Brown & Williamson Tobacco Corp. would like to give you a few facts about *Viceroy*.

Only Viceroy gives you, your patients, and all cigarette smokers 20,000 Filter Traps in every filter tip. These filter traps, doctor, are composed of a pure white non-mineral cellulose acetate. They provide the maximum filtering efficiency possible without affecting the flow of smoke or the full flavor of Viceroy's quality tobaccos.

Smokers report Viceroys taste even better than cigarettes without filters.



King-Size Filter Tip

VICEROY

World's Most Popular Filter Tip Cigarette

Only a Penny or Two More Than Cigarettes Without Filters





BOOK REVIEWS (Continued)

of the Council on Pharmacy and Chemistry of the American Medical Association. Published by W. B. Saunders Company, Philadelphia and London, New Third Edition, 89 Illustrations.

Copyright 1954 $6.00

Basically, this is a textbook for medical students and those who are called upon to give anesthetics incidental to their regular practice.

The subject matter is well organized, the illustrations and line drawings are clear and appropriate. The reader is left with a firm foundation in the fundamental principles of anesthetics and anesthetic agents and devices. No hard and fast procedures are advocated. The physician is urged to fit the anesthetic of choice to particular patient and the peculiar circumstances surrounding a given set of conditions. Throughout the text admonitions and pithy statements of anesthetic truths are dramatically set off in boxes at the foot of the page. This is a splendid textbook.

BOOKS RECEIVED

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

Ciba Foundation Colloquia on Endocrinology. Volume VIII. The Human Adrenal Cortex. Editors for the Ciba Foundation. G. E. W. Wolstenholme, O.B.E., M.A., M.B.B.Ch., and Margaret P. Cameron, M.A., A.B.L.S., Assisted by Joan Etherington. 227 illustrations. Little, Brown and Company, Boston, 1955. $10.00.

Survey of Clinical Pediatrics. By Lawrence B. Slobody, M.D., Professor of Pediatrics, New York Medical College, Director of Pediatrics, Flower and Fifth Avenue Hospitals, Metropolitan Hospital; Medical Director, Children's Center, New York City. Second edition. The Blakiston Division of McGraw-Hill Book Company, Inc., New York, Toronto and London, 1955. $9.50.

Essentials of orthopaedics. By Philip Wiles, M. S. (Lond.), F. R. C. S. (Eng.), F. A. C. S. Senior Orthopaedic Surgeon, The Middlesex Hospital, London, and King Edward Memorial Hospital, Ealing,

(*Continued on page* 50)

METICORTEN

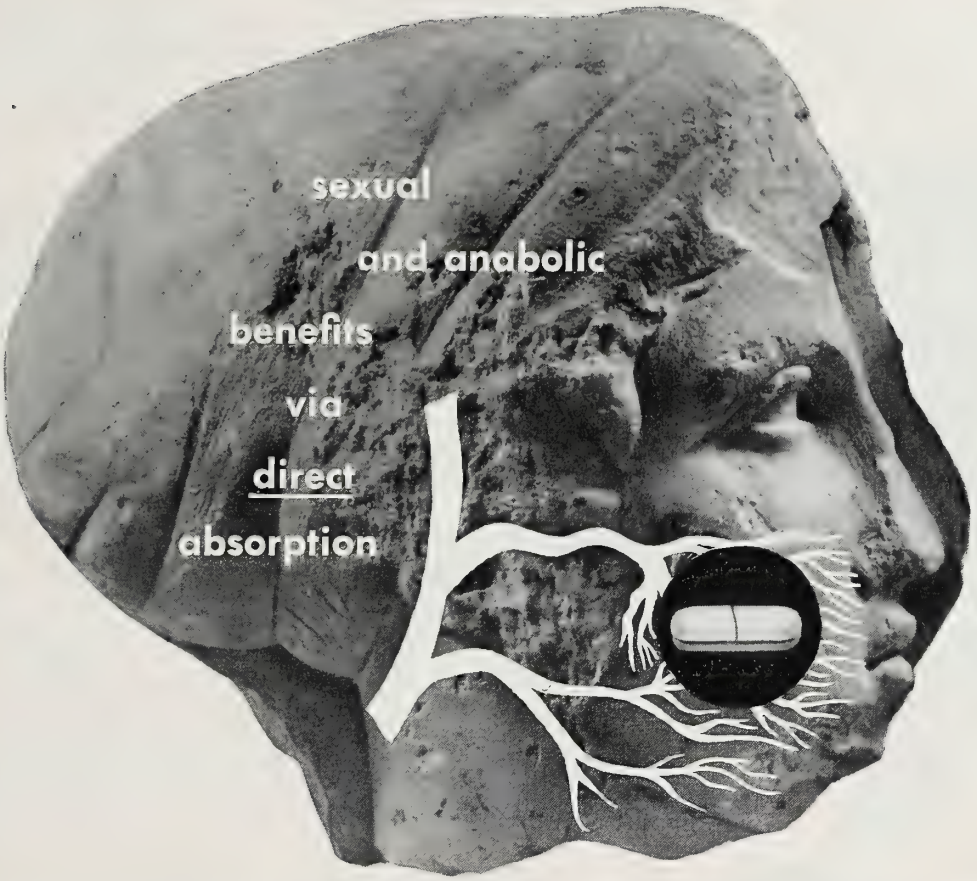
PREDNISONE (metacortandracin)

Schering

more potent than cortisone
or hydrocortisone · devoid of
major undesirable side effects

*T.M.

Meticorten,* brand of prednisone.



METANDREN® LINGUETS®

the most potent oral androgen

FEMANDREN® LINGUETS®

the most potent oral estrogen with the most potent oral androgen

Buccally or sublingually absorbed LINGUETS by-pass liver inactivation or gastric destruction—are virtually as potent as parenteral steroids—provide effective, convenient, low-cost hormone therapy.

Supply: Metandren Linguets, 5 mg. (white, scored) and 10 mg. (yellow, scored). Femandren Linguets (green, scored), each containing 0.02 mg. ethinyl estradiol and 5 mg. methyltestosterone.

Metandren® (methyltestosterone U.S.P. CIBA)
Femandren® (methyltestosterone with ethinyl estradiol CIBA)
Linguets® (tablets for mucosal absorption CIBA)

C I B A Summit, N. J.

2/ 2079M

WE CORDIALLY INVITE YOUR INQUIRY for application for membership which affords protection against loss of income from accident and sickness (accidental death, too) as well as benefits for hospital expenses for you and all your dependents.



SINCE 1902

ALL PREMIUMS COME FROM

PHYSICIANS SURGEONS DENTISTS

ALL BENEFITS GO TO

$4,500,000 ASSETS
$22,500,000 PAID FOR BENEFITS

PHYSICIANS CASUALTY AND HEALTH ASSOCIATIONS
OMAHA 2, NEBRASKA

BOOKS RECEIVED (Continued)

Lecturer in Orthopaedic Surgery, The University of London, President-Elect The British Orthopaedic Association. Second edition. 7 color plates and 393 text figures. Little, Brown and Company, Boston, 1955. $10.

Obstetrics. By J. P. Greenhill, M. D., Senior Attending Obstetrician and Gynecologist, The Michael Reese Hospital, Obstetrician and Gynecologist, Associate Staff, The Chicago Lying-in Hospital; Attending Gynecologist, The Cook County Hospital; Professor of Gynecology, Cook County Graduate School of Medicine. Eleventh edition. 1008 pages. 1170 illustrations, 910 figures, 144 in color. W. B. Saunders Company, Philadelphia and London, $14.00.

The medical significance of anxiety. By Richard L. Jenkins, M. D., Chief, Psychiatric Research, Psychiatry and Neurology Service, Veterans Administration, Washington 25, D. C., The Biological Sciences Foundation, Ltd., Washington 7, D. C. $1.00.

Reserpine in The Treatment of Neuropsychiatric, Neurological, and Related Clinical Problems. Annals of the New York Academy of Sciences. Volume 61, Art. 1, Pages 1-280. April 15, 1955. Editor, Roy Waldo Miner. $3.50.

Tea—A Symposium on the Pharmacology and the Physiologic and Psychologic Effects of Tea. Henry J. Klaunberg, Ph. D., Editor. The Biological Sciences Foundation, Ltd., Washington 7, D. C. $1.00.

‹ ›

The sinus and brain abscess

The next most dangerous complication of acute sinus infection, without actual meningitis, is subdural empyema. This is an unusual happening and in my own experience, most commonly associated with fulminating frontal sinus disease. Some puffiness of the related orbit is then often an external sign of frontal osteitis. Drowsiness, stupor, hemiparesis, and meningeal reaction then document the intracranial extension. *Derek Denny-Brown, M.D. The Clinical Problem of Aseptic Meningitis. Rhode Island M.J. April* 1955.

‹ ›

The decline in mortality from tuberculosis has been proportionally greater in women than men, adding to the already existing inequality in the number of living men and women in the late years of life. Men, however, have been dying from tuberculosis at a later age than formerly, neutralizing some of the discrepancy, while adding years to their own productive period of life. Esmond R. Long, M.D., Bull. Hist. of Med. July-Aug, 1954.

upport recovery, speed convalescence

Tetracyn® SF*

BRAND OF TETRACYCLINE

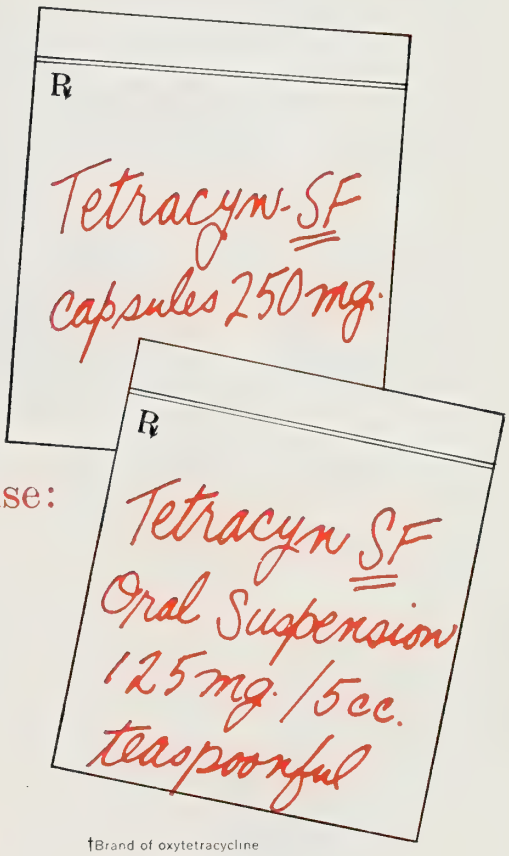
the leading broad-spectrum antibiotic, discovered by Pfizer

with water-soluble vitamins in combinations originated by Pfizer

For patients with infections, "one must aim at maintaining the normal daily nutritional requirements, replacing previous depletions and current losses, and supplying whatever increased requirements may be related to the nature of the illness."[1] This is the concept of "treating the 'whole' patient."[2]

Tetracyn SF has antibiotic effectiveness equal to that of Tetracyn® alone[3] and, in the hands of thousands of physicians, has shown

Equivalent Blood Levels[3]
Superior Toleration[4]
Accelerated Recovery[5]



Two effective dosage forms for oral use:

Terramycin† SF* ***is also available.***

Tetracyn SF and Terramycin SF are formulated to provide with the minimum daily dose of each antibiotic (1 Gm. of Tetracyn or Terramycin) the stress vitamin formula recommended by authorities on nutrition.[1]

1. Pollack, H., and Halpern, S. L.: Therapeutic Nutrition, Prepared in Collaboration with the Committee on Therapeutic Nutrition, Food and Nutrition Board, National Research Council, Washington, D. C., 1952. 2. Martí-Ibáñez, F.: Antibiotic Med. *1*:247 (May) 1955. 3. Dumas, K. J.; Carlozzi, M., and Wright, W. A.: Antibiotic Med. *1*:296 (May) 1955. 4. Milberg, M. B., and Michael, M., Jr.: Ann. New York Acad. Sc., In press. 5. Prigot, A.: Ibid.

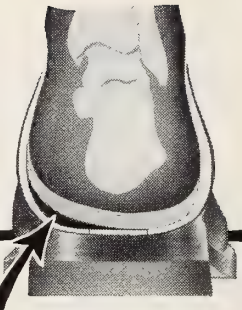
†Brand of oxytetracycline

*Trademark for Pfizer brand of antibiotics with vitamins.

Pfizer

PFIZER LABORATORIES, Brooklyn 6, N.Y.
Division, Chas. Pfizer & Co., Inc.

Foot-so-Port Shoe Construction and its Relation to Weight Distribution



• Insole extension and wedge at inner corner of heel where support is most needed.

• Special Supreme rubber heels are longer than most anatomic heels and maintain the appearance of normal shoes.

• The patented arch support construction is guaranteed not to break down.

• Innersoles are guaranteed not to crack, curl, or collapse. Insulated by a special layer of Texon which also cushions firmly and uniformly.

• Foot-so-Port lasts were designed and the shoe construction engineered with orthopedic advice.

• Over nine million pairs of men's,women's and children's Foot-so-Port Shoes have been sold.

• By a special process, using plastic positive casts of feet, we make more custom shoes for polio, club feet and all types of abnormal feet than any other manufacturer.

Write for details or contact your local **FOOT-SO-PORT** *Shoe Agency. Refer to your Classified Directory*

Foot-so-Port Shoe Company, Oconomowoc, Wis.

Mercy Hospital Institute of Radiation Therapy

The Henry Schmitz Medical Group

For Appointment
VIctory 2-4700, Ext. 170 or RAndolph 6-4444

Herbert E. Schmitz, M.D., *Director*
Peter A. Nelson, M.D., *General Oncology*
Henry L. Schmitz, M.D., *Internal Medicine*
Janet Towne, M.D., *Gynecology*
Robert L. Schmitz, M.D., *General Surgery*
John F. Sheehan, M.D., *Pathologist*
Charles J. Smith, M.D., *Gynecology*
Charles S. Gilbert, M.D., *Internal Medicine*
William F. Cernock, M.D., *Internal Medicine*
Fred W. Eims, *Physicist*
Miss Hilda Waterson, R.N.
Helen Hansen, *Social Service*

COMPLETE TUMOR THERAPY
Including
SUPERFICIAL X-RAY THERAPY
DEEP X-RAY THERAPY up to 1,000 K.V.
RADIUM THERAPY

Daily Consultation at Institute
Tumor Clinic—Mercy Free Dispensary—Tuesday at 9 a. m.
Tumor Conference — J. B. Murphy Auditorium — Friday at 1 p. m.

Endocrine substances

Many factors must be considered in the treatment of gynecologic dysfunctions by means of endocrine substances, factors which may be local and organic, or constitutional and systemic, or of a specific endocrine character. Many of the gynecologic disorders which lend themselves to endocrine therapy have two characteristics which vitiate accurate evaluation — namely, a self-limited course and an associated psychogenic facade. The remissions which characterize gonadal dysfunctions make it difficult to differentiate, particularly in the course of treatment, spontaneous amelioration from therapeutic cure. The emotional impact of disorders which are in one way or another related to gonadal function cannot be denied. It is thus apparent that prior to the prescription of any endocrine substance, a complete survey of the whole patient should be made in order to identify psychogenic influences and any physical disorder which would preclude the use of the substance in question. As an example of the latter, one may cite the importance of carefully examining the breasts and genital organs of any menopausal woman prior to the prescription of estrogen. *S. Leon Israel, M.D. Gonadotropins and Gonadal Steroids in Gynecology. J. Albert Einstein Med. Cent. Feb.* 1955.

‹ ›

Therapeutic handicaps

A patient with duodenal ulcer of any duration hardly can be expected to respond to medical treatment when his occupation consists of something like driving a bus or street car in the intricacies of modern traffic and at the same time is expected to make change and handle the general public when it is weary, irritable, and belligerent during peak hours of traffic. His hours are erratic, his eating periods are irregular, and his emotions are subject to great stress. He cannot afford the time from work and the relaxation incident to a satisfactory medical regimen. It might also be stated that on the other hand, when he has had an operative procedure, he is going back to these stresses and should the procedure not prove satisfactory, he promptly returns to the same surgeon. *William F. Quinn, M.D. Duodenal Ulcer: Prejudices Regarding Surgical Treatment. Arizona Med. April* 1955.



for hay fever patients



preserve summer pleasures with these advantages

- ✓ unusually rapid relief
- ✓ outstanding freedom from side effects
- ✓ maximum convenience

in the greatest variety of oral forms

CHLOR-TRIMETON REPETABS, 8 mg.
up to 12 hours of uninterrupted relief reported with just one dose

CHLOR-TRIMETON REPETABS, 12 mg.
for prolonged therapy in more difficult cases

CHLOR-TRIMETON Tablets, 4 mg.
for initiating therapy, maintenance therapy or adjusting dosage

CHLOR-TRIMETON REPETABS with Sodium Pentobarbital,
¾ gr. for nightlong relief and assured sleep

CHLOR-TRIMETON Syrup, 2 mg. per 4 cc.
palatable, compatible liquid

CHLOR-TRIMETON® maleate, brand of chlorprophenpyridamine maleate.
REPETABS,® Repeat Action Tablets.

SCHERING

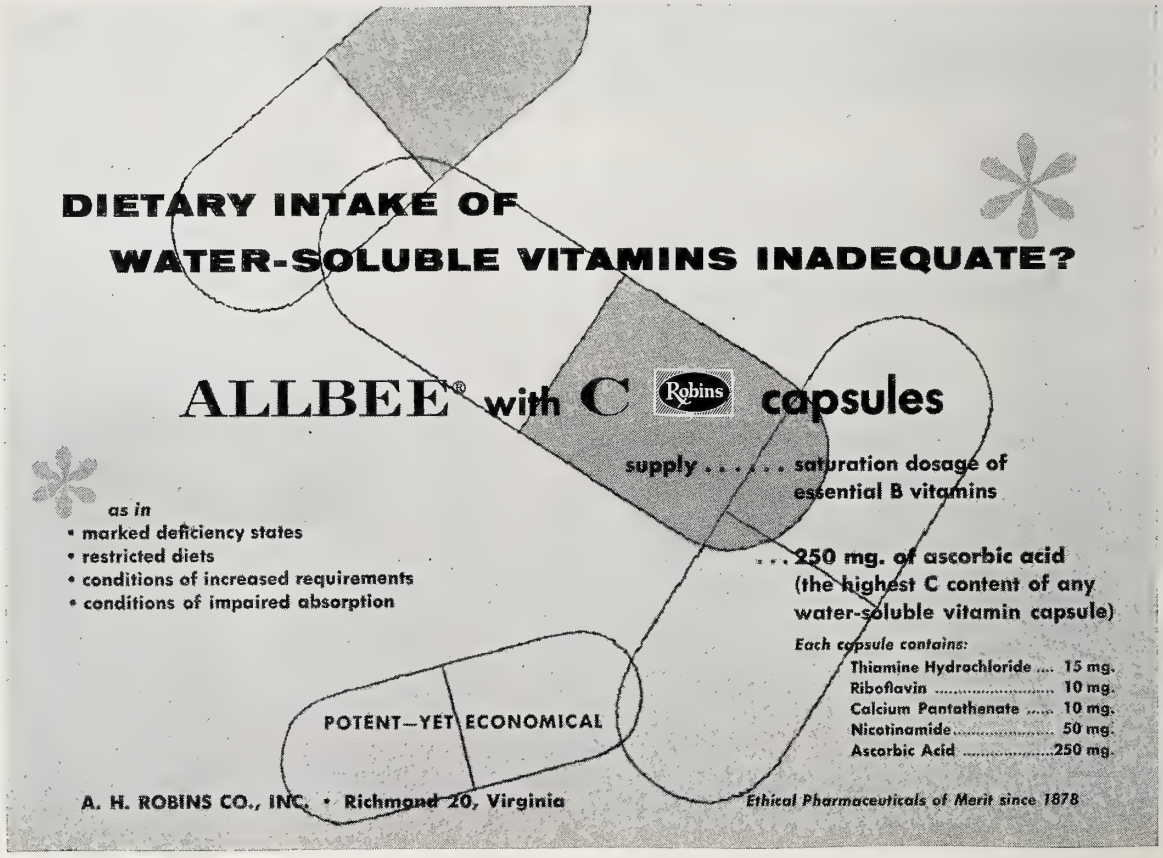
CT-J-56

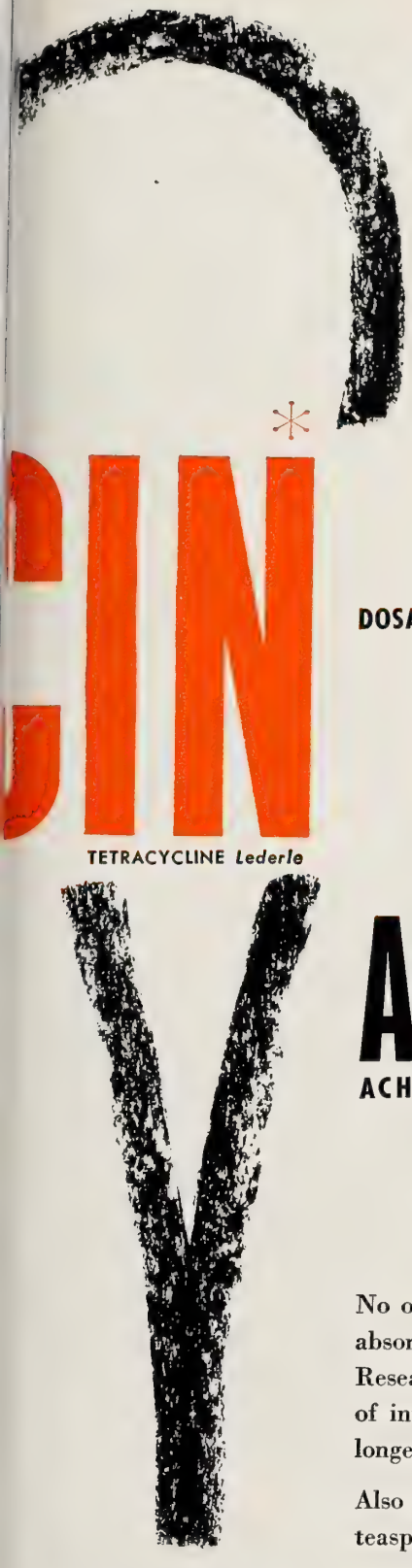
The diagnosis of L. E.

Systemic lupus erythematosus is a disease of unknown cause. Aggravating factors are recognized; they include infection, exposure to sunlight or cold, various allergic reactions, and surgical procedures. The constitutional symptoms occurring during active phases of the disease are fever, weakness, fatigue, prostration, and loss of weight. Arthralgias and joint symptoms are seen in many of the patients, and many times it is difficult to distinguish between systemic lupus erythematosus and rheumatoid arthritis, without prolonged follow-up. Various cutaneous manifestations have been described, among them the classic open butterfly wings on the face. Signs and symptoms of disturbances of the central nervous system or of the lesions of the pulmonary and cardiovascular systems occur frequently. Lymphadenopathy and splenomegaly occur in more than 50 per cent of the patients. In 1948, Hargraves and associates described a peculiar cell in the buffy layer of bone marrow taken from patients who had acute and subacute lupus erythematosus. This cell, known as the L.E. cell, is a mature polymorphonuclear leucocyte containing an ingested or lysed mass of homogenous, pale-purple material thought to be of nuclear origin. *Gertrude L. Pease, M. D., Value of the L.E. Clot Test. Nebraska M.J., Feb.* 1955.

The home care of tuberculosis

Beyond question, there is a place and an enlarging one for home care of tuberculosis. But the limitations of home treatment must be recognized. Its real place is in the care of patients who have been treated satisfactorily by chemotherapy or an appropriate combination of drug treatment and surgery for a proper period in a tuberculosis hospital, and whose continuing treatment in these days of long term chemotherapy can be integrated carefully at home with the regime of previous months in that hospital. This is the optimum field for private practice in the care of tuberculosis. For the great majority of tuberculous patients, initial hospital care is highly desirable. *Esmond R. Long, The Care of Tuberculosis in Private Practice. Philadelphia Med., Oct.* 8, 1954.





TETRACYCLINE *Lederle*

DOSAGE FORMS FOR EVERY NEED...A CHOICE OF POTENCIES!

New!

ACHROMYCIN Sf

ACHROMYCIN WITH STRESS FORMULA VITAMINS



dry-filled sealed capsules—a Lederle exclusive! No oil, no paste, tamper-proof. More rapidly and completely absorbed. Stress vitamin formula as suggested by the National Research Council. Prescribe ACHROMYCIN SF for prompt control of infection and rapid patient recovery, particularly in prolonged illness. *Capsules of 250 mg.*

Also available: ACHROMYCIN SF Oral Suspension: 125 mg. per teaspoonful (5 cc.), 2 oz. bottle.

Lederle

LEDERLE LABORATORIES DIVISION *AMERICAN Cyanamid COMPANY* Pearl River, New York

*REG. U. S. PAT. OFF.

METICORTEN
PREDNISONE (metacortandracin)
more potent than cortisone or hydrocortisone • devoid of major undesirable side effects
Schering
SCHERING
METICORTEN,* brand of prednisone.
*T.M.

Surgeon General twice honored

The Surgeon General of the U. S. Air Force, Major General Dan C. Ogle, was the recipient of two high civilian awards within the month of June. During the convocation ceremony of the American College of Chest Physicians, held in Atlantic City on 4 June 55, he was presented with an Honorary Fellowship in the College. The College is an international society and a fellowship such as this is a singular honor.

On June 12, 55, at Eureka, Illinois, during the centennial commencement of Eureka College, General Ogle was presented a centennial citation as being representative of outstanding achievement in his particular field. He is a graduate of Eureka College prior to his receiving an M.D. degree from the University of Illinois.

General Ogle is a Flight Surgeon as well as a graduate of the Air War College. During the latter part of World War II he was Staff Surgeon of the 15th Air Force and in 1953 returned to Europe as Surgeon of the U. S. Air Force in Europe.

General Ogle was born in Keithsburg, Illinois, where for a time he taught school before continuing his studies.

‹ ›

The whirlpool bath

The most efficient method of heating the hand is the whirlpool bath. This consists of immersing the hand for 10 to 15 minutes in rapidly whirling water maintained at a temperature of approximately 105 degrees. Besides the effect of heat, there is the added advantage that, with relief of some of the pain by the whirling water, the patient can do active exercises in the water by squeezing a sponge or rubber bulb. This treatment should be given daily if possible. Ordinary hot soaks should not be used by the patient at home, unless he has been carefully instructed and can be trusted to do active exercise while soaking. *S. Malvern Dorinson, M.D. Physical Medicine for Injured Hands. California Med. April* 1955.

‹ ›

Possessions, outward success, publicity, luxury — to me these have always been contemptible. I believe that a simple and unassuming manner of life is best for everyone, best both for the body and mind. — *Albert Einstein*



Trasentine®-Phenobarbital

- Inhibits Parasympathetic Activity
- Relaxes Smooth Muscle Directly
- Exerts Local Anesthetic Effect on G-I Mucosa
- Sedates the Patient

Without Atropine Side Effects

Each tablet contains 50 mg. Trasentine hydrochloride and 20 mg. phenobarbital.
Also available: Trasentine hydrochloride Tablets, 75 mg.

Trasentine® hydrochloride
(adiphenine hydrochloride CIBA)



2/2061M

C I B A *Summit, N. J.*

To the point

I can recall only part of a talk I once heard at a sales meeting. I think the speaker had a point. He said, "You are talking to a parade. Three million Americans never saw an elephant, that is why the circus will come back next year." "Same old stuff," you say, "Same stunts, same clowns, same animals, same ballyhoo you saw when you were a kid."

"Yes, largely true, of course, but since the same old elephant stalked through the streets a year ago, three million new Americans will have arrived in this country — three million more people who have never seen an elephant. That's why the same old elephant walks serenely confident that among every bored group of people who say 'That's just an elephant' some eager young voice will shout, 'Oh, That's an elephant.' "

You are not talking to a grandstand, you are talking to a parade. I think this applies to teaching. The simple experiment that first aroused our interest in physics will have the same effect upon each new group that comes to us for instruction. *R. C. Grubs. Demonstrations in High School* (1948) *quoted in Scientific Month. June* 1955. *Physics. School Science and Mathematics* 11:199

‹ ›

Young coronaries

The recent report by Enos and associates on autopsy findings in 300 soldiers killed in battle or by accident in Korea is rather startling. The average of this group was only 22.1 years but in 77.3 per cent of them, gross evidences of coronary artery disease were found. This work would suggest that three-fourths of the males in this country have already developed gross coronary lesions when they are still in their early 20s. This appears to be the foundation for death at age 50. Considering such a long evolution of pathology, it is not surprising that short term therapy, dietary or otherwise, as we practice it today, does so little for the patient. *J. R. Kitchell, M.D., Management of the Patient with Coronary Atherosclerosis. J. Oklahoma Med. A., Feb.* 1955.

Lederle

FOLBESYN*

Vitamins *Lederle*

A well-balanced, high-potency vitamin formula containing B-Complex and C

FOLBESYN provides B-Complex factors (including folic acid and B_{12}) and ascorbic acid in a well balanced formula. It does not contain excessive amounts of any one factor.

FOLBESYN Parenteral may be administered intramuscularly, or it may be added to various hospital intravenous solutions. It is useful for preoperative and postoperative treatment and during convalescence.

Dosage: 2 cc. daily. Each 2 cc. provides:

Thiamine HCl (B_1)	10 mg.
Sodium Pantothenate	10 mg.
Niacinamide	50 mg.
Riboflavin (B_2)	10 mg.
Pyridoxine HCl (B_6)	5 mg.
Ascorbic Acid (C)	300 mg.
Vitamin B_{12}	15 micrograms
Folic Acid	3 mg.

FOLBESYN is also available in tablet form, ideal for supplementing the parenteral dose.

LEDERLE LABORATORIES DIVISION AMERICAN Cyanamid COMPANY Pearl River, New York

*REG. U.S. PAT. OFF.

sulfa the

- highest potency
- wide spectrum
- minimal side effects
- highest blood, plasma, and tissue levels
- safety
- economy

In every important way, judged by any test, the Council-accepted Triple Sulfas are still unexcelled among sulfa drugs. Constant use for many years has thoroughly proved their great worth. It is not surprising, then, that most leading pharmaceutical manufacturers offer the Triple Sulfas under their own brand names in a variety of forms, both alone and combined with other therapeutic agents.

These preparations are drugs of choice in many systemic, gastrointestinal, and urinary infections. Next time you find a sulfa drug is indicated, prescribe one of these effective preparations. For details, *ask any medical representative about the Triple Sulfa products his company offers.*

Triple Sulfas

SULFADIAZINE **SULFAMERAZINE** **SULFAMETHAZINE** Meth-Dia-Mer Sulfonamides

Cyanamid Fine Chemicals

AMERICAN Cyanamid COMPANY

FINE CHEMICALS DIVISION

30 ROCKEFELLER PLAZA, NEW YORK 20, N. Y.

specify

LEDERLE

POLIOMYELITIS IMMUNE GLOBULIN

(human)

Lederle

For the modification of measles and the prevention or attenuation of infectious hepatitis and poliomyelitis.

LEDERLE LABORATORIES DIVISION
AMERICAN Cyanamid COMPANY Pearl River, New York

Ben and the common cold

Almost 185 years ago Benjamin Franklin, who was completely unfettered by any concern with hemagglutination inhibitions or complement-fixation tests for the identification of the agents of the common cold or the criteria of cytopathogenesis, pronounced as follows on this banal but costly condition: "I have long been satisfied from observation that people catch cold from one another when shut up together in close rooms and coaches, and when sitting and conversing so as to breathe each other's transpiration; the disorder being in a certain state." A homely virtue in this observation from "Poor Richard's Almanac" is in danger of being lost in the highly scientific attempts to culture infectious agents on neoplastic Hela cells or in Roller-tube cultures of embryonic lung or skin. *Editorial, Poor Richard's Catarrh. New England J. Med. Apr.* 21, 1955.

‹ ›

There is honor in labor. Work is the medicine of the soul. It is more: it is your very life, without which you would amount to little. — *Grenville Kleiser*



A NEW EXPERIENCE IN MOOD ELEVATION

Rauwidrine—combining 1 mg. Rauwiloid® and 5 mg. amphetamine in a single tablet—replaces despondence with equanimity—provides serenity and pleasant alertness for the depressed and melancholy, the dispirited and frustrated patient—all without euphoria, without barbiturate drag. Safe for the hypertensive, too.

Dosage: For mood elevation, initially 1 to 2 tablets before both breakfast and lunch.

Rauwidrine®

Riker LABORATORIES, INC., Los Angeles

FOR OBESITY Rauwidrine curtails appetite without the "black mood" feeling of deprivation.





the soothing, protective, healing[1-4] *influence of*

DESITIN®
OINTMENT

is persistent

because it adheres longer to the skin areas being treated . . . does not liquefy or crumble at body temperature, nor is it decomposed by secretions, perspiration, exudate, urine, or excrement.

Non-sensitizing, non-irritant Desitin Ointment . . . rich in cod liver oil . . . has proven clinically dependable for over a quarter century in . . . **diaper rash • eczemas intertrigo • wounds** (especially slow healing) **external ulcers • perianal dermatitis**

Tubes of 1 oz., 2 oz., 4 oz., and 1 lb. jars.



samples and reprints available from

DESITIN CHEMICAL COMPANY • 70 SHIP STREET PROVIDENCE 2, R. I.

1. Grayzel, H. G., Heimer, C. B., and Grayzel, R. W.: New York St. J. M. 53:2233, 1953.
2. Heimer, C. B., Grayzel, H. G., and Kramer, B.: Archives of Pediatrics 68:382, 1951.
3. Behrman, H. T., Combes, F. C., Bobroff, A., and Leviticus, R.: Ind. Med. & Surg. 18:512, 1949.
4. Turell, R.: New York St. J. M. 50:2282, 1950.

Recurrent breast cancer

Randall, of the New York Memorial Hospital for Cancer, feels adrenalectomy may be considered as a possible additional means of temporary control of advanced breast cancer, particularly in cases which have shown a response to castration. Huggins feels that all patients undergoing operation for carcinoma of the breast should then, or in a short period of time thereafter, undergo bilateral oophorectomy because of the known influence of these glands upon the life of many such tumors. This is a prophylactic step. When definite metastasis occurs, bilateral adrenalectomy is then performed. The New York Memorial group advise castration once metastates have manifested themselves in the premenopausal patients and, if the results are favorable, bilateral adrenalectomy and oophorectomy is performed. It is generally agreed that approximately 40 per cent of such patients undergo significant palliation. Taylor reported upon 11 patients treated with cortisone alone and not adrenalectomitized, stating they did not receive the same amount of palliation as those who were. Numerous authors agree that there is no method known for predicting which patients may be expected to respond favorably. *Jesse P. Eddy, 3d, M.D. Bilateral Adrenalectomy and Oophorectomy in the Treatment of Recurrent Carcinoma. Rhode Island M.J. April* 1955.

‹ ›

Ambition

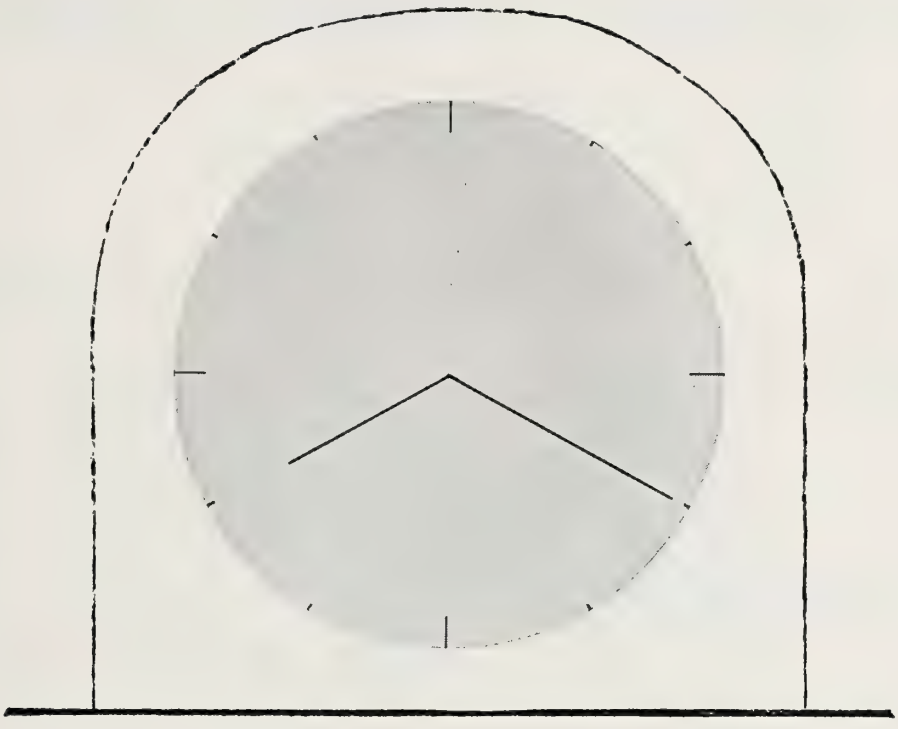
"At 20 I knew I would amass the great American fortune.
At 30 I knew I would write the great American novel
At 40 I knew I would become a Socrates for sagacity.
At 50 I know better".

Clifton Fadiman

‹ ›

For centuries malaria has rivalled if not surpassed tuberculosis as the most disabling disease of mankind. Also, like tuberculosis, it has undergone a striking decline in prevalence in recent years that raises hope for its ultimate eradication. It has ceased to be a problem in certain large sections of the world where a few generations ago every inhabitant was infected. Esmond R. Long, M.D., Bull. Hist. Med. July-Aug., 1954.

METICORTEN
PREDNISONE (metacortandracin)
Schering
SCHERING
more potent than cortisone
or hydrocortisone · devoid of
major undesirable side effects
*T.M.
METICORTEN,* brand of prednisone.



round-the-clock antihistamine protection

Green writes: "Last year I obtained for investigational use, the antihistamine chlorprophenpyridamine maleate, so prepared . . . that its resultant therapeutic effect was designed to last approximately twelve hours following the administration of a single oral dose."

After giving this preparation ('Teldrin' *Spansule* capsules) to 357 allergic patients, Green reported:

"The results . . . confirm the postulated long-acting property and low side effect liability of ['Teldrin' *Spansule* capsules]."

Green, M.A.: Ann. Allergy *12*:273

Teldrin*

chlorprophenpyridamine maleate

Spansule*

brand of sustained release capsules

Antihistamine

In 2 dosage strengths:
8 mg. (1 dot on capsule) &
12 mg. (2 dots on capsule)

One 'Teldrin' *Spansule* capsule q12h provides 24-hour uninterrupted, sustained antihistamine protection from a wide range of allergic manifestations.

made only by

Smith, Kline & French Laboratories, Philadelphia

the originators of sustained release oral medication

*T.M. Reg. U.S. Pat. Off. Patent Applied For.

The NORBURY SANATORIUM

JACKSONVILLE, ILLINOIS — INCORPORATED and LICENSED

For the Treatment of Nervous and Mental Disorders

FRANK GARM NORBURY, M.D., Medical Director
HENRY A. DOLLEAR, M.D., Superintendent
FRANK B. NORBURY, M.D., Associate Physician

Address Communications — THE NORBURY SANATORIUM, Jacksonville, Illinois

DOCTOR! you will approve the 3C's
Comfort, Cleanliness, Convenience



at Bee Dozier's 3 Sanitariums for Aged, Chronic, Senile, Convalescent Patients.

Hickory Hill,
Maple Hill, *Palatine*

Charming, healthful rural locations conveniently situated, 24 hour care by trained nurses and orderlies, tempting food and supervised diets all contribute to your patient's well-being or recovery. 18 years of experience.

ONE rate covers EVERYTHING. There are NO extras.

Bee Dozier invites your inspection. Write Box 288, Lake Zurich, Ill., or Phone 4661

The ABC of cancer

There are many factors which affect the success of treatment in cancer but there are two which are of such fundamental importance they are frequently overlooked. First, the physician cannot start treatment for cancer until the patient presents himself to the physician, and second, the physician does not initiate therapy until the diagnosis has been definitely established. Educational efforts which emphasize the importance of seeing a physician regularly and stress the need of early diagnosis in this disease are being carried out vigorously by the medical profession, the American Cancer Society and its local units, and health departments. In addition, good medical practice demands that the diagnosis of cancer be established by pathologic examination. *Paul R. Gerhardt, M.D. and Vincent H. Handy, M.D. Factors Related to Cancer Treatment. New York J. Med. June* 1, 1955.

‹ ›

Health cannot be dissociated from the particular conditions under which man has to function. It implies fitness to his total environment. Rene J Dubos, Ph.D., Nat. Tuberc. A. Tr., May, 1954.

North Shore Health Resort

on the shores of Lake Michigan
WINNETKA, ILLINOIS

NERVOUS and MENTAL DISORDERS
ALCOHOLISM and DRUG ADDICTION
Modern Methods of Treatment
MODERATE RATES

Established 1901 — *Fully Approved by the*
Licensed by State of Illinois — *American College of Surgeons*

SAMUEL LIEBMAN, M.S., M.D.
Medical Director

225 Sheridan Road — Winnetka 6-0211

CARDIAC EDEMA
GLAUCOMA
EPILEPSY

now benefited by

Diamox*

Acetazolamide Lederle

DIAMOX has proved to be a very effective, safe, and convenient oral diuretic for use in controlling cardiac edema. In fact, it is now the most widely prescribed drug of its type. Recent evidence shows it is useful in two other important ways:

IN EPILEPSY

DIAMOX suppresses both the frequency and the severity of seizures, without apparent direct sedative action. DIAMOX appears to produce a relative acidosis in a manner similar to the ketogenic diet, and may also have a direct effect on nerve tissue. (1)

IN ACUTE GLAUCOMA

significant reduction in intraocular pressure is produced by oral administration of DIAMOX. This probably results from a decrease in the secretion of aqueous humor. DIAMOX also appears to enhance the action of commonly employed miotics. (2)

One product . . . three uses . . . a versatile therapeutic agent!

Available in 250 mg. tablets for oral use
and 500 mg. ampuls for intravenous use.

1. Merlis, S.: DIAMOX: A Carbonic Anhydrase Inhibitor—Its Use in Epilepsy. Neurology. 4:11, 863-866 November 1954.

2. Becker, B.: Decrease in Intraocular Pressure in Man by a Carbonic Anhydrase Inhibitor, DIAMOX. Am. J. Ophth. 37:1, 13-15 January 1954.

*REG. U.S. PAT. OFF.

Lederle LEDERLE LABORATORIES DIVISION AMERICAN Cyanamid COMPANY PEARL RIVER, NEW YORK

FAIRVIEW
Sanitarium

DEVOTED TO THE ACTIVE TREATMENT OF

MENTAL and NERVOUS DISORDERS

Specializing in Psycho-Therapy, and Physiological therapies including:

- Electro-Shock
- Electro-Narcosis
- Insulin Shock
- Carbon Dioxide Therapy

Out Patient Shock Therapy Available

ALCOHOLISM Treated by Comprehensive Medical-Psychiatric Methods.

2828 S. PRAIRIE AVENUE, CHICAGO 16 J. DENNIS FREUND, M. D., Medical Director

Phone Victory 2-1650 Registered by the American Medical Assn.

Do You Know ? ? ?

THE SPECIAL DISABILITY PLAN

AVAILABLE TO MEMBERS OF

THE ILLINOIS STATE MEDICAL SOCIETY

Provides Benefits up to . .

$5000. ACCIDENTAL DEATH AND DISMEMBERMENT

$100. PER WEEK FOR TOTAL LOSS OF TIME as the result of either Sickness or Accident.
$15. DAILY HOSPITALIZATION for up to 90 days as the result of either Sickness or Accident.

Plus . . .

Optional 5 Year Sickness Coverage
No reduction in benefits because of other insurance
Full benefits to age 70 at same cost
(All Benefits Subject to Provisions of the Policy)

FOR ALL THE FACTS - - -
Write or Telephone

PARKER, ALESHIRE & COMPANY

175 W. JACKSON BOULEVARD
Chicago 4, Ill. WAbash 2-1011

The hepatitis carrier

Carriers of serum hepatitis are common. It is estimated that 0.2-0.5 per cent of the general population may be carriers, and the incidence of serum hepatitis following blood transfusions is between 0.45 and 1 per cent. There is no known way of detecting these carriers or of sterilizing the blood donated by carriers. Recent papers indicate that almost all carriers have abnormalities in their liver function tests and that it may be possible, with selected liver function tests, to screen donors and thus to eliminate some of the carriers of serum hepatitis. The risk of transmitting serum hepatitis always must be kept in mind in giving blood transfusion. It is a factor that must be accepted as a calculated risk. *M. William Barry, M.D. The Control and Prevention of Acute Viral Hepatitis. Nebraska M.J. May* 1955.

‹ ›

Those whom you can make like themselves better will, I promise you, like you very well. — *Lord Chesterfield.*

in whooping cough

ELIXIR BROMAURATE

GIVES EXCELLENT RESULTS

Cuts short the period of illness and relieves the distressing spasmodic cough. Also valuable in Bronchitis and Bronchial Asthma.

In four-ounce original bottles. A teaspoonful every 3 to 4 hours

Prescribed by Thousands of Doctors

GOLD PHARMACAL CO. NEW YORK CITY

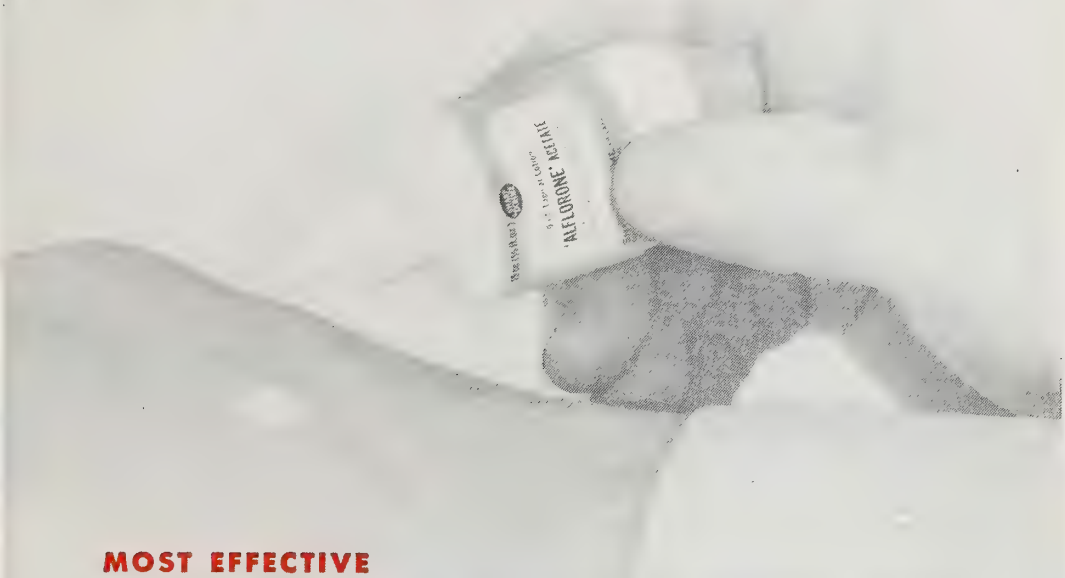
WEIGHT FOR WEIGHT,
THE MOST EFFECTIVE ANTI-INFLAMMATORY
AGENT YET DEVELOPED
FOR TOPICAL USE

TOPICAL LOTION

'ALFLORONE'

ACETATE

(FLUDROCORTISONE ACETATE, MERCK) 9 ALPHA-FLUOROHYDROCORTISONE ACETATE



MOST EFFECTIVE
Therapeutically active in 1/10th the concentration of hydrocortisone (Compound F).

MOST ECONOMICAL
Superior spreading qualities—a small quantity covers a wide area.

MOST ACCEPTABLE
Most patients prefer the cosmetic advantages of this easy-to-apply, smooth spreading lotion.

Supplied in a cosmetically elegant base in two concentrations: 0.25% and 0.1% in 15 cc. plastic squeeze bottles.
Also available: Alflorone Topical Ointment in 5 gm. tubes—two concentrations—0.25% and 0.1%.

SHARP & DOHME

Philadelphia 1, Pa.
DIVISION OF MERCK & CO., INC.

THE
MEDICAL PROTECTIVE
COMPANY
FORT WAYNE, INDIANA

the doctor's most secure source of security

PROFESSIONAL PROTECTION
EXCLUSIVELY
SINCE 1899

CHICAGO Office:
T. J. Hoehn, E. M. Breier and
W. R. Clouston, Representatives,
1142-44 Marshall Field Annex Building,
Telephone State 2-0990

SPRINGFIELD Office:
F. A. Seeman, Representative,
Telephone Springfield 4-2251

Safe plasma

Dried pool plasma is one of the common sources of serum hepatitis. One infected donor is sufficient to contaminate the entire pool. The incidence of serum hepatitis after plasma transfusions may be as high as 20 per cent in large pools. Various procedures have been resorted to in an attempt to sterilize the plasma. The use of ultraviolet radiation for this purpose has not been found reliable. In liquid environment the virus is not as stable as it is in the dried state and some observers have reported that if pooled plasma is stored at room temperature for six months in the liquid state, its use carries almost no risk of serum hepatitis. When stored under those conditions there are no harmful alternations in the plasma. After such storage, the plasma might be dried if necessary, and its use would be safe. *M. William Barry, M.D. The Control and Prevention of Acute Viral Hepatitis. Nebraska M.J. May* 1955.

‹ ›

It's amazing what ordinary people can do if they set out without preconceived notions.

— Charles F. Kettering

Relax the best way
... pause for Coke



Time out for refreshment

DRINK
Coca-Cola
REG. U.S. PAT. OFF.



NO ONE IS COMPLETELY IMMUNE

BONAMINE*

* BRAND OF MECLIZINE HYDROCHLORIDE

Motion sickness affects people of all ages because almost everyone is sensitive to labyrinthine irritation induced by travel on land and sea and in the air.

Bonamine has proved unusually effective to prevent and treat this minor but distressing complaint. And a new agreeable method of administration is now offered by the incorporation of this well-tolerated agent, with its prolonged action, in a pleasantly mint-flavored chewing-gum base. 90% of the drug content becomes available in only five minutes of chewing.

Bonamine is also indicated for the control of nausea, vomiting and vertigo associated with labyrinthine and vestibular disturbances, post-operative status, Menière's syndrome and radiation therapy.

Supplied:

Bonamine Tablets *(scored and tasteless) 25 mg.*

New
Bonamine Chewing Tablets *25 mg.*



Pfizer

PFIZER LABORATORIES, Brooklyn 6, N.Y.
Division, Chas. Pfizer & Co., Inc.



MARY POGUE SCHOOL, Inc.

Complete facilities for training retarded and epileptic children educationally and socially. Pupils per teacher strictly limited. Excellent educational, physical and occupational therapy programs.

Recreational facilities include riding, group games, selected movies under competent supervision.

Separate buildings for boys and girls under 24 hour supervision of skilled personnel.

Catalog on request

G. H. Marquardt, M.D. — *Medical Director*

Barclay J. MacGregor — *Registrar*

33 GENEVA ROAD, WHEATON, ILLINOIS

(near Chicago)

Classified Ads

RATES FOR CLASSIFIED ADVERTISEMENTS—For 30 words or less: 1 insertion, $3.00; 3 insertions, $8.00; 6 insertions, $14.00; 12 insertions, $24.00; from 30 to 50 words: 1 insertion, $4.00; 3 insertions, $10.50; 6 insertions, $20.00; 12 insertions, $30.00. Extra words: 1 insertion 10c each; 3 insertions, 25c each; 6 insertions, 40c each; 12 insertions, 50c each. A fee of 25c is charged for those advertisers who have answers sent care of the Journal. Cash in advance must accompany copy.

FOR SALE: Spencer microtone complete with freezing attachment. Price $175.00. Call Central 6-1565 or Mansfield 6-2388. 9/55

X-ray therapy

Most physicians who use X-ray in treatment of skin malignancies try not to use X-ray therapy to cancerous or precancerous lesions on the hands or fingers. This avoids the sometimes adverse effects of the X-ray on the small bones and cartilage in those areas. There is much argument, however, as to when one must or must not treat lesions over the cartilage of the nose or ears with X-ray therapy. These areas are hard to treat by scalpel and thus X-ray therapy is considered. There has been much refinement in the last several years in the technic by which these areas are treated by X-ray. As a result, there have been fewer cases in which there has been damage of a permanent nature to the underlying cartilages. It is best, I believe, in such cases to use another method of treatment if possible or practicable. *Thomas F. B. Darnell, M.D. Cancerous and Precancerous Changes of the Skin. Missouri Med. May* 1955.

‹ ›

Fool me once, shame on you; fool me twice, shame on me.

— Chinese Proverb.

THUMBSUCKING

since infancy caused this malocclusion.



THUM TRADE MARK

THUM broke the habit and teeth returned to normal position.

ACCEPTED FOR ADVERTISING IN PUBLICATIONS OF THE AMERICAN MEDICAL ASSOCIATION

Get Thum at your druggist or surgical dealer. Prescribed by physicians for over 20 years.

BELLEVUE PLACE

For NERVOUS and MENTAL DISEASES

★

Edward Ross, M.D., Medical Director

BATAVIA ILLINOIS — **PHONE BATAVIA 1520**

Give us the fortitude to endure the things which cannot be changed, and the courage to change the things which should be changed, and the wisdom to know one from the other.

— Bishop Oliver J. Hart

THE KEELEY INSTITUTE

DWIGHT, ILLINOIS

Treating alcoholism and other problems of addiction.

REGISTERED BY THE AMERICAN MEDICAL ASSOCIATION— MEMBER AMERICAN HOSPITAL ASSOCIATION.

Table of Contents

September, 1955
Vol. 108, No. 3

Editor
Harold M. Camp
Monmouth, Illinois

Associate Editor
Theodore Van Dellen
Chicago, Illinois

Business Manager and Managing Editor
Mr. L. E. Malley
185 N. Wabash Avenue
Chicago 1, Illinois

Business Office
185 N. Wabash Avenue
Chicago 1, Illinois

Editorial Office
Medical Arts Building
Monmouth, Illinois

Send original articles and membership correspondence to Harold M. Camp, Monmouth, Ill.

Send changes in the mailing list to Managing Editor, 185 N. Wabash Ave., Chicago 1, Ill.

Subscription price of this JOURNAL to persons not members of the Illinois State Medical Society is $4.00 per year, in advance, postage prepaid, for the United States, Cuba, Puerto Rico, Philippine Islands, Hawaiian Islands and Mexico. $5.00 per year for all foreign countries included in the postal union. Canada, $4.50. Single current copies 50 cents. By mail, 60 cents.

ORIGINAL ARTICLES

The Treatment of Threatened Abortion, Richard Paddock, M.D., St. Louis, Mo. 167
Veratrum Derivatives in the Treatment of Toxemia of Pregnancy, Paul A. Raber, M.D., Decatur 171
Acute Intestinal Obstruction, Irving Rudman, M.D., Frankfort 175
A New Agent for Control of Dermatological Problems in Nurseries, Herbert E. Schmitz, M.D. and Margaret Scannell, M.D., Chicago 177
The Management of Stasis Dermatitis, Myron H. Kulwin, M.D., Champaign 179
Foreign Body ("Fish Bone") Granuloma (Cook Co. Case Record) Eli T. Samet, M.D. and Samual J. Fogelson, M.D., F.A.C.S., Chicago 182
Pulmonary Embolism in Poliomyelitis, (Case Report) J. Keller Mack, M.D., Springfield 185
Guillain-Barre Syndrome Simulating a Herniated Intervertebral Disk, (Case Report) Louis D. Boshes, M.D., and Philip Lewin, M.D., Chicago 190

PATHOLOGY CONFERENCES

1. Thrombosis of the basilar artery
2. Aneurysmal hemangiectasis (hemangioma) of the cerebrum
Edwin F. Hirsch, M.D., St. Luke's Hospital, Chicago 192

EDITORIALS

Thyroid cancer in childhood 196
Importance of small hospitals to the nation 196
The nation's physician population 197
New ruling tells what are and what are not deductible medical expenses 198
The history of medical practice in Illinois 199

CORRESPONDENCE

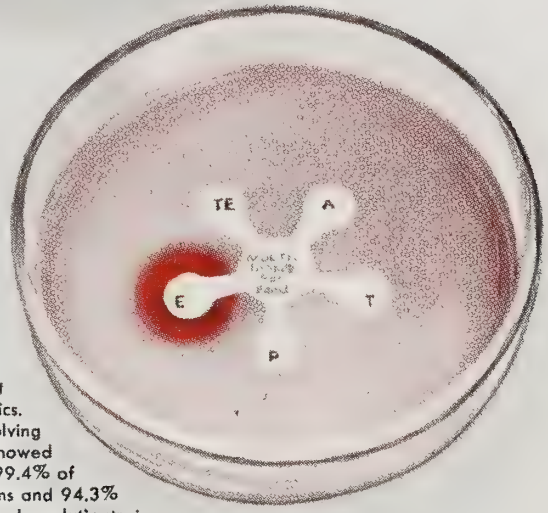
New changes and procedures in the doctor draft 200
Twenty clinics for crippled children listed for October 200
Academy of Psychosomatic Medicine 201
Military surgeons to discuss medical aspects of atomic warfare 201
A.M.A. sponsoring three regional medical-legal conferences 202
Financial aid for student nurses 202
Exhibit on uterine cancer test available 203
Announcement of the Van Meter Prize Award 203
American Dermatological Association annual prize essay contest .. 203
Midwest Conference on Rheumatic Diseases 204
Army to pay higher entrance rates to civilian physicians 204
I.A.G.P. postgraduate program 205
Officers of the Chicago Society of Allergy 205
Second graduate course in plastic surgery of the head and neck 205
New ophthalmology journal 205
Hospitals to be published twice monthly 205

THE P.R. PAGE 206

NEWS OF THE STATE 208

Entered as Second-Class Matter November 12, 1952 at the Post Office, Mendota, Illinois, under the Act of March 8, 1879. Acceptance for mailing at special rate postage provided for in section 1102, Act of October 8, 1917, authorized July 15, 1918. Printed monthly by The Wayside Press, Mendota, Illinois. Office of Publication, 1501 W. Washington Road, Mendota, Illinois. POSTMASTER — Return undeliverable copies under form 3579 to 1501 W. Washington Road, Mendota, Illinois.





DESTROYS ENTEROCOCCI

This blood agar plate shows a strain of *beta* hemolytic enterococcus. Note extreme sensitivity of this organism to ERYTHROCIN—yet it easily resists the other antibiotics. Additional data: A study[1] involving 202 enterococcic strains showed sensitivity to erythromycin in 99.4% of *alpha* hemolytic strains and 94.3% of *beta* hemolytic strains.

specific against coccic infections

Now, you can prescribe *specific therapy* against staph-, strep- or pneumococci by simply writing *Filmtab* ERYTHROCIN Stearate. Since this coccic group causes most bacterial respiratory infections (and since these organisms are the very ones most sensitive to ERYTHROCIN) doesn't it make good sense to prescribe *Filmtab* ERYTHROCIN when the infection is coccic?

filmtab®

Erythrocin®

(Erythromycin Stearate, Abbott)

STEARATE

The
ILLINOIS
Medical Journal



Official Journal of The Illinois State Medical Society

SEPTEMBER 1955
VOL. 108 NO. 3

The Treatment of Threatened Abortion

Richard Paddock, M.D., St. Louis, Mo.

FROM the beginning of treatment in a case of threatened abortion the object of treatment should be two-fold. First, fetal salvage if at all possible. Second, the reduction of maternal morbidity so that regardless of the outcome of the pregnancy, the mother will not be impaired as to health or the possibility of future pregnancy. Both of these objects are of the greatest importance to the patient and cannot be too strongly emphasized.

As a matter of interest, threatened abortion or fear of abortion was considered by the ancients when they brought flowers as votive offerings to the Goddess Juno to guard against abortions.

In Hippocratic medicine a sudden loss of fullness of the breasts in a pregnant woman indicated a miscarriage.

Soranus, in the first century A. D., writing on diseases of women mentioned pain in the loins, pelvis, and lower abdomen as well as fever, shivering, a discharge becoming bloody, and passage of clots as signs of abortion.

As the art and practice of obstetrics advanced, with recognition of the signs and symptoms of pregnancy, the recognition of signs and symptoms of the deviation from the normal became more and more evident. Now it isn't so much a matter of recognition of abnormal signs as it is a matter of treatment when these occur.

Most cases of threatened abortion show symptoms at about eight to ten weeks of gestation. Some may do so much earlier and some later, depending upon the cause of the threatened interruption of pregnancy.

The first symptom is usually that of a bloody vaginal discharge. That is the reason a large number of patients make the first visit to the physician. After obtaining a history of the case, such a patient should have a careful vaginal examination to determine the possibility of an existing pregnancy and to determine if possible the source of the bleeding. Many patients in early pregnancy will bleed from congestion of an everted or eroded cervix, or they may have a cervical polyp which is prone to bleed with pregnancy. Malignancy of the cervix may also be present. The advantage of a careful examination in such a patient far outweighs any possible harm that might be done. In this way one may discover an ectopic pregnancy.

Should the bleeding, or bloody discharge be seen coming from within the cervical canal then

---

Presented before the General Assembly, 114th Annual Meeting, Illinois State Medical Society, Chicago, May 18, 1954.

the patient should be treated as a case of expected threatened abortion.

In the instance of a patient calling in to report a probable pregnancy with a bloody discharge, I believe it best to put the patient to bed, and keep in contact from day to day, until the bleeding ceases or increases. I believe the disadvantage of the patient making the trip in for an examination outweighs the advantage of seeing her and examining her, at once.

In most cases, if the progress of threatened abortion is advanced, there will be pain and tenderness. The pain usually becomes cramp-like in nature as the result of the accumulation of blood in the uterine cavity or the attempt on the part of the uterus to expell clots and products of conception. When severe cramping occurs, it is usually a sign that separation of the products of conception is in progress. Pain and cramping should be relieved for the comfort of the patient, as well as the slowing down of the process of abortion. For the relief of pain, especially in the case of the patient at home, I believe there is nothing better than divided doses of paregoric, for it can be given safely over a long period of time as needed.

Where one closely follows a large number of pregnant women, in early pregnancy, it is seen that a rather high percentage, probably about twenty-five per cent, will show some bloody discharge in the first trimester of pregnancy. If the causes of bleeding previously mentioned can be ruled out, there is still a fair number that unquestionably show a bloody discharge from within the cervical canal, and still go on to term. This may be due to physiological causes as in the case of some animals when placentation takes place. However, in human beings any bleeding in early pregnancy should be considered as a threatened abortion until the cause of bleeding can be determined.

When abortion threatens, the first step in the treatment is to get the patient under control. Absolute bed rest is the primary treatment, along with enough sedation or analgesics to keep her comfortable. Many patients have the idea that if an abortion is about to take place, it is best to be up and about to "get it over with" if it is to take place. This is a mistaken idea and the patient should be told that regardless of the outcome, if abortion does take place, the slower it goes, the easier and safer it is. Moving about on one's feet may cause more rapid and more profuse bleeding, thus making it necessary to hospitalize the patient for a longer period of time or require operative intervention or transfusions on account of blood loss.

If the bleeding persists without further progressive symptoms, the patient should be kept in bed for at least twenty-four hours after the bloody discharge has ceased. This may require several days or even longer, but in most cases the blood loss will not be as great and should termination of the pregnancy follow, separation will be more complete with a lower incidence of hospitalization and curettage.

Assuming that bleeding ceases after any twenty-four hour period, the patient may sit up for a day and if there is no further bleeding, she may be about with caution for the next few days. Should bleeding recur, then she should go back to bed as before. This is a sensible and conservative way of handling such cases, and over the years, has proven to be a safe and economical way of treating threatened abortion.

In a recent paper by A. W. Diddle and Associates on the "Evaluation of Bed Rest in Threatened Abortion," it was shown that the use of bed rest apparently has little or no effect on fetal loss from threatened abortion. This is probably true from the standpoint of fetal loss; on the other hand, I believe in bed rest as a conservative and economic treatment for the mother.

In this day and age, no work on the treatment of threatened abortions would be complete without consideration of hormonal therapy. This is a controversial subject. There are many advocates of hormonal therapy as a "must" in treatment of threatened abortion. There are many who feel that it is purely empirical, useless, and futile.

The first hormones used, aside from thyroid therapy, were the ovarian substances. The logic for this form of therapy was shown by the necessity of a corpus luteum of pregnancy to remain present in the ovary until the pregnancy was well advanced. For this reason, var-

ious extracts of corpus luteum were prepared for administration to patients threatening to abort. Some of these preparations had no pharmacological activity while others, developed much later, contained progesterone, the active principle of the corpus luteum.

As experiments went on and clinical data was accumulated, it was fairly well shown that progesterone alone was not all that was needed, and that it was of little avail without the administration of Estrin. Hence came the use of estrogenic substances in the treatment of threatened abortion.

As of today, numerous courses of treatment with various forms of synthetic estrogens have been outlined. So varied are the many preparations and dosages recommended that it is evident that they can't all be right.

Most of us have been circularized by certain manufacturers claiming a preposterous percentage of fetal salvage by the use of their preparations. It is obvious from one's own personal experience with such cases that such high percentages of salvage are not obtainable.

If we step into the pathological laboratory of any of our hospitals and ask our pathologist to get out specimens and descriptions of material received from abortion cases we can soon see that a very large number examined in the routine way show obvious defects that made the interruption of pregnancy inevitable. This, of course, is no recent discovery. Many years ago when collections of fetuses were being obtained for museum purposes, it was noted that a high percentage showed pathology in the placental tissues, or in the developing fetus that would account for the failure of pregnancy to continue. In every case of abortion, I try to get the patient or her family to bring in all material passed, if in the home. In the hospital the material automatically goes to the laboratory. If this material is properly examined it can be seen in many, many cases that some abnormality is present. In the last four cases where material was brought in from the outside, I found no fetus present in the ovisac. The case of the blighted ovum. Most of these anomalies occur early, often before the patient knows she is pregnant, so the duration of the pregnancy is self limited and no amount of hormonal therapy would have produced a viable child.

The variety of these abnormalities is numerous. To mention some, we have: blighted ovum, blood mole, carneons mole, hermatoma mole, hydatid mole, placenta circumvallata, fetal anomalies of various external appearance such as: hydrocephalus, anencephalus, spina bifida, meningo coele, and no doubt other malformations and anomalies undetected after expulsion of the products of conception.

I mention these because it is well to consider the things with which we may be dealing in treating threatened abortion.

Consideration should be given to the patient in early pregnancy who gives a history of repeated abortions. The frequency with which spontaneous interruption of pregnancy occurs in any given case may be purely coincidental. On the other hand, if a patient has a history of several previous spontaneous abortions, one should assume that this tendency should or may be habitual. In a recent paper by Berle and Javert, they classify as "primary habitual abortion" in the obstetrical patient who has had three or more consecutive spontaneous abortions beginning with the first pregnancy, and "secondary habitual abortion" in those who have had three or more consecutive abortions following delivery of one or more full term or premature infants.

When such a patient presents herself as a case of early pregnancy, I believe that she should be considered as a case of threatened abortion based on past history alone, without any signs or symptoms of trouble. The first thing to emphasize is freedom from emotional and physical stress. Then all necessary arrangements for rest should be made in advance of any threatening symptoms. At the first suggestion of trouble complete bed rest should be instituted.

A systematic course of hormonal therapy may then be started, building up the dosage as pregnancy advances. With rational doses of estrogenic substances there is probably no harm to be done, and if there is any benefit from this type of therapy, these are the cases in which the hormones may work to best advantage.

As was mentioned earlier, a considerable number of patients will bleed in early pregnancy. Some will bleed a rather large amount, so much that abortion would seem inevitable.

In spite of this the occasional patient will continue to advance in pregnancy. One such patient was discharged from the hospital a few days ago. She did have a premature labor after spontaneous early rupture of the membranes, but delivered a five pound, six ounce child in good condition. This patient in the first few weeks of pregnancy had cramps and free bleeding, along with the passage of clots to the extent that it was assumed that she had had an early abortion. The only significant findings at the time of delivery were a rather small, thin placenta showing numerous thin fibrinous infarcts beneath the fetal surface.

During the course of early threatened abortion some patients will show some elevation of temperature. I believe if it were possible to take frequent temperature readings on all cases there would be seen some temperature elevation. This is perhaps a vasomotor disturbance and is not a matter of infection. There are cases threatening to abort where the termination is not yet to be considered inevitable but in which the course of temperature reaction is beginning to appear septic. In such cases antibiotic drugs should be started at once and continued as indicated. If such a patient is anaemic at the outset, transfusion should be given. If the extent of bleeding is such that packing of the cervix and vagina is imperative, then it should be done with the thought that further conservation of the pregnancy is hopeless. This is fortunately a rare situation and may not occur in one's practice where abortion is only threatened and not obviously inevitable.

In the conservative treatment of threatened abortion the attitude of the practitioner should be that of optimism and hopefulness. To properly treat these women who are frequently temporarily upset and despondent it is most important to try to build and maintain their morale. The prospect of an indefinite period of enforced bed rest is disheartening at the outset. Day to day reports and telephone conversations are a good method of building morale and also saves unnecessary residence calls where the patient is at home in bed. Persistence in conservative treatment is the keynote in treating threatened abortion.

REFERENCES

Graham, Harvey: "Eternal Eve" Doubleday, 1951. Chap. III; p. 36.

Graham, Harvey: "Eternal Eve" Doubleday, 1951. Chap. IV; p. 75.

Graham, Harvey: "Eternal Eve" Doubleday, 1951. Chap. V; p. 92.

Waters, Edward G. "Early Pregnancy Hemorrhages" Bulletin Margaret Hague Maternity Hospital: December, 1952.

Diddle, A. W. & Associates "Evaluation of Bed Rest in Threatened Abortion." Obst. & Gynec. 2:63-67; 1953.

Berle, B. B. and Javert, C. T. "Stress and Habitual Abortion" Obst. & Gynec. 3:298-306; 1954.

4500 Olive Street

Aortic regurgitation

Among all sounds emanating from the human heart, the "dove-coo," or "sea-gull" murmur is unique. None so closely approximates a pure musical tone and none is so clearly perceived by the ear. Its flowing note, characteristically decrescendo and sliding downward in pitch as it is prolonged through most of the diastole, bears a starting resemblance to the coo of a dove. Variously described as the "sea-gull cry," the "humming top," or "whistling" murmur, it is referred to in most cardiology textbooks simply as the musical murmur of aortic regurgitation. Its differentiation from ordinary murmurs which may occasionally possess some degree of "musical quality" usually is quite obvious on auscultation, enabling one to recognize it readily as a specific type of heart murmur. *Dale Groom, M.D. and John A. Boone, M.D. The "Dove-Coo" Murmur and Murmurs Heard at a Distance from the Chest Wall. Ann. Int. Med. June* 1955.

Veratrum Derivatives in the Treatment of Toxemia of Pregnancy

Paul A. Raber, M.D., Decatur

THE value of veratrum viride in the treatment of toxemia of pregnancy has been a controversial subject ever since it was first used almost 100 years ago.

J. R. Willson in giving a brief history of the drug mentioned that Paul D. Baker in 1859 was apparently one of the first to try the drug in the toxemias. He must not have had much success because later he is quoted as saying that "veratrum viride has seen its day". In 1894 Winter stated, in essence, that veratrum viride had again been discovered and was being used rather extensively. But again it lost its popularity and was discarded in favor of newer methods by almost everyone. However, one of the few places where veratrum viride was not forsaken was at the Cincinnati General Hospital. Here it has been used continually and successfully for the past 50 years.

Bryant in 1935 and Bryant and Fleming in 1940 enthusiastically urged veratrum viride to be used as an adjunct to the treatment of eclampsia principally because of its vasodilating properties. This initiated a new surge of interest in its application to the toxemias of pregnancy and during the last few years there has been an increasing number of reports on the use of veratrum viride in one form or another with encouraging results.

DEFINITION

Veratrum viride is obtained from the roots and rhizome of a plant of the Liliaciae (or Lily) family. It consists of many different alkaloids, some of which have never been identified. However, there are some dozen of these alkaloids which have been isolated and several of them are now being used medically for hypotensive purposes. Each of these that is being used for such purposes has been standardized as to potency and has been made a sterile preparation. I will mention several of these later in my discussion.

CLINICAL EFFECTS AND PHARMACOLOGY

One of the main objections in the past to the use of veratrum viride arose from the fact that it was not standardized nor the principles isolated. Because of this, the effectiveness of the drug was hampered by the use of crude extracts which were variable in composition and effect, making dosage adjustment difficult and toxic reactions frequent. Both of these objections have been overcome as there are now available purified, well-assayed extracts of uniform potency which permit standard dosage schedules, thus greatly simplifying the use of the drug.

Another objection to the use of veratrum viride which has been constantly raised is its effect on the urinary output. There is no doubt that a temporary decrease in urine volume is observed after the first injection of veratrum, particularly when the blood pressure drops markedly. However, this transitory oliguria is later compensated for by a polyuria which almost always results in an actual urinary increase for the 24-hour period compared to the output for the previous 24 hours. Assali believes that this initial decrease in urine volume is caused by readjustment of the kidney to the drop in the blood pressure and possibly by an increased secretion of anti-diuretic hormone due to emotional reaction to the drug or other factors. He states that there is no evidence to indicate that this transitory oliguria constitutes any danger to the patient's life.

A third objection in the past to the use of veratrum viride has been the marked frequency of nausea and vomiting and other side reactions. There has been a marked reduction of toxic and vomiting reactions with the isolation and use of most all of the newer alkaloid preparations. One of the newer preparations has been found to require a higher dosage for the emetic effect than the hypotensive effect. This finding

Presented before the Section on Obstetrics and Gynecology, 114th Annual Meeting, Illinois State Medical Society, Chicago, May 18, 1954.

plus better standardization and purification has helped to reduce the side reactions.

Despite extensive pharmacological studies, the exact mode of action of veratrum viride remains unknown. Judging from a large number of investigations, it seems that this drug acts by producing *arteriolar* vasodilatation without affecting the *venous* side of the circulation. Thus, a decrease in the peripheral resistance and a drop in blood pressure is obtained without any marked effect on the cardiac output or any postural hypotension. It appears that the mechanism of the hypotensive action is chiefly central in origin with the reflex hypotension being secondary. The exact nature or locus of this central action has not been elicited. Veratrum also causes a definite bradycardia in the patient which apparently is due to its stimulating action on the vagus nerve.

RECENT INVESTIGATIONS

In November 1951 Baird and Assali at the Cincinnati General Hospital reported a series of 35 pre-eclamptic and 3 convulsive eclamptic patients who were treated both intravenously and intramuscularly by a veratrum viride preparation made by Irwin-Neisler Pharmacal Company. The trade name is Verenteral and is a sterile tincture of the crude drug veratrum viride which was standardized in rabbits and dogs. They stated that their clinical results were very satisfactory with an adequate vasodepressor response in all the cases treated. No convulsions occurred after they had started treatment with the drug. They felt that as an adjunct in the treatment of pre-eclampsia and eclampsia, Verenteral had proved to be of decisive value. Although much remains to be learned concerning its pharmacological action, its vasodepressor effect is well established.

In November 1952 Alban, Dennis and Swanson at Mr. Carmel Mercy Hospital in Detroit reported ten cases of either severe pre-eclampsia or eclampsia treated with Veratrone used intravenously. Veratrone is an alkaloid preparation of veratrum viride made by Parke-Davis. Eight of these ten cases had been treated by other methods with failure of response and an increase in severity of symptoms. They reported that all patients treated with I.V. Veratrone showed prompt fall and stabilization of blood pressure and improvement of symptoms. No appreciable amount of urinary depression was noted and most patients develop polyuria within 12 hours following the use of the drug. Symptoms of nausea, flushing of the face and burning of the throat were common side reactions, but extreme nausea and vomiting was encountered in only one patient.

Alban was very impressed with the value of Veratrone in the control of severe toxemia where failure was evident with other methods. He believes that the hypertension in toxemia is a result of the generalized vasospasm characteristic of the disease and prompt reduction is very important. Therefore, the hypotensive effects that he realized with his use of veratrum viride were very encouraging for further use of it.

In October 1953 Finnerty & Fuchs of Georgetown University in Washington, D. C. reported a study which was done to better evaluate veratrum viride, using the alternate case technique. Fifty patients with severe pre-eclampsia received purified extracts of veratrum viride given I.M. and 50 patients received pentobarbital and magnesium sulfate given I.V. Twelve patients with eclampsia were treated with purified extracts of veratrum given I.V. and compared to 12 patients with eclampsia treated with pentobarbital and magnesium sulfate.

Three purified products of veratrum viride were used: Vergitryl (Squibb), Veriloid (Riker) and Unitensen (Irwin-Neisler).

In the veratrum group (A) and in the Pentobarbital & Mg SO_4 group (B) the mean diastolic BP response was as follows:

(A) a fall of 23 mm Hg .....
..... a fall of 28 mm Hg

(B) an increase of 4 mm Hg .....
..... a fall of 1.3 mm Hg

Veratrum	*Pentobarbital & Mg SO_4*
Normal pulse rate or bradycardia	Tachycardia
Convulsions — 6 after treatment	9
No oliguria	50% oliguria
No anuria	25% anuria
2 fetal deaths	4 fetal deaths
No maternal deaths	1 maternal death
12 cases — mild vomiting	

In an uncontrolled study there were an additional 308 patients with non-convulsive toxemia treated with veratrum given intramuscularly.

The results of this group were as follows:		*Excellent*	*Good*	*Fair*	*Poor*
Severe pre-eclamp.	30	22	6	1	1
Mild pre-eclamp.	150	126	18	3	3
Postpartum	81	70	8	3	0

Finnerty concludes from his data that veratrum therapy, because it controls the diastolic blood pressure and pulse rate and maintains consciousness, is a more effective method of management of toxemia of pregnancy than the pentobarbital and Mg SO_4 regime.

At the University of Cincinnati General Hospital a recent report shows there have been 205 consecutive eclamptic patients treated with veratrum viride in one form or another in the last 20 years. There were three maternal deaths giving an uncorrected maternal mortality rate of 1.5%. Only one of these deaths resulted from eclampsia per se, giving a corrected maternal mortality rate of less than 0.5%. It is superfluous to point out that that is indeed an outstanding and enviable record in the treatment of eclampsia. They have long advocated the use of veratrum viride in toxemia and in view of their statistics, they have evident reason for such advice.

There are other similarly good reports in the literature recently, using one or another of the purified and standardized extracts of veratrum viride which I am not going to take time to mention.

Our* experience in Decatur in the use of veratrum viride with toxemias of pregnancy is relatively limited. During the past three years we have treated ten of our more severe toxemias of pregnancy with extracts of veratrum viride prepared by the Irwin-Neisler Pharmacal Company of Deacatur. Their most recent preparation which we are using at the present time is called Unitensen. Unitensen contains the active hypotensive alkaloid, Cryptenamine, which has been isolated from veratrum viride.

Repeated experimentation has demonstrated that the emetic response requires three to four times the dose required for the hypotensive response. Naturally this property of the alkaloid is valuable in reducing the amount of nausea and vomiting in the patient when giving the drug.

In our group there were eight severe pre-eclamptics and two eclamptics. Out of the eight pre-eclamptics, there were five that showed excellent responses, two good and one just fair. One of the eclamptics had an excellent response and the other good.

In general we felt our results were good but seemingly not as good as some of the reports I've just mentioned. We were able to control the blood pressure in our patients to some degree in all cases. There was usually a good response at first and then there were periods when the usual doses seemed to have no effect and it was necessary to increase the dose. In several of the patients it was found that it was not necessary to try to maintain the blood pressure at or below 140/90, but at a level which was ten points or more higher, depending on what seemed a relatively good improvement for that patient. The intravenous therapy proved more effective but it was definitely more delicate and required more rigid supervision.

We had no untoward effects as far as urinary output was concerned. Six of the ten had some nausea and vomiting — two were fairly severe episodes but none were severe enough to make it necessary to discontinue the drug. For the most part we used the veratrum alkaloid in our more severe toxemias and we discontinued its use when our patients were in relatively good condition, despite the fact that blood pressures were still above normal. No convulsions occurred after the drug was started. In conjunction with the veratrum viride, we also used the following drugs: Magnesium sulfate, orally, intravenously and intramuscularly; 5% glucose in $H2_0$ and Na Phenobarbital.

I personally feel that veratrum viride is of very definite value in the toxemias of pregnancy and particularly the more severe ones. I think that when you have a standardized and

*Drs. Vern Cannon Jr., Vernon Long, Phillip Lynch, James B. Waller.

sterilized alkaloid of veratrum viride available for use, it gives you a sense of security with your severe pre-eclamptics and eclamptics that you don't have otherwise. At least you know you can control the blood pressure in almost all cases, thus controlling your convulsions and much minimizing the possibility of a cerebral vascular accident.

Briefly, our schedule for the use of Unitensen intramuscularly was as follows: 0.5 cc (1 mg) I.M. stat. Blood pressure and pulse rate were recorded every 15 minutes after this first dose and then every half hour thereafter. 0.5 cc was repeated whenever the blood pressure was over 140/90. It was given as often as every hour when necessary. The dosage was increased 0.1 cc when there was no hypotensive effect. The most we gave in one dose was 1 cc (2 mg). Sodium Phenobarbital was used for nausea and vomiting.

Intravenous therapy for emergency use such as convulsions were as follows: 0.5 cc (1 mg) of Unitensen was mixed with 20 cc 5% glucose and given intravenously at the rate of 1 cc per minute until there was a fall of 20 mm systolicor 10 mm diastolic. Thereafter, the solution was given slowly whenever the blood pressure went over 140/90. It is obvious that giving the drug intravenously requires constant and close supervision and is a delicate procedure. After the blood pressure had been stabilized for 24 to 48 hours, if a viable fetus was present, the easiest method of delivery was restored to. The same routine was followed until the blood pressure had become stabile and most of the symptoms had disappeared.

CONCLUSION

As has been mentioned before, veratrum is by no means the final answer or the specific treatment for the toxemias of pregnancy. Neither is parenterally given veratrum effective nor is it practical for long-term therapy, for tolerance not uncommonly develops after 5-6 days. Furthermore, one cannot justly attribute the overall good response in our cases or the others reported solely to the drug for, in most cases, other medications were used and early delivery promoted. However, we do feel that the veratrum definitely aids in controlling the blood pressure and pulse rate. It simplifies the management of toxemias by enabling us to do away with the heavy sedation which we otherwise used. Thereby the incidence of respiratory complications are reduced and the patient is better able to maintain an adequate intake of fluid and nourishment. Also without the heavy sedation, subjective symptoms are more easily elicited and the baby is in better condition in case of operative or spontaneous delivery.

We now have standardized and sterilized alkaloids of veratrum viride which are entirely safe and easy to administer. The dosages can be relied upon and, with reasonable care, there should be no precipitous blood pressure drops or severe side reactions. So far as anyone knows there are no particular deleterious effects on the patient from the use of the drug.

Oliguria and anuria are not problems since profound hypotension is not produced with the more recently standardized alkaloids. Actual polyuria has often been the case after treatment with veratrum. The effects of hypotension and bradycardia are certainly very much to be desired in the toxemias of pregnancy. Hypertension, as a result of generalized vasospasm, unless reduced is certain to cause a number of cerebral vascular accidents and death.

It seems therefore that veratrum viride preparations can definitely be of value as an adjunct in the treatment of the toxemias of pregnancy. The vasodilator action on the arteriolar system thus decreasing the peripheral resistance, the lowering of the blood pressure without any marked postural hypotension, and the effect of bradycardia without any effect on cardiac output, all seem to recommend the action of veratrum, as a rational approach in the basic treatment of such a disease as the toxemias of pregnancy.

SUMMARY

I have tried to present a short resume of the progress made in preparation of a more practical and effective alkaloid of veratrum viride for use in toxemia of pregnancy. I have also tried to give you a brief of some of the reports of its use by several of the more recent investigators. And lastly, I have presented my thoughts about the use of veratrum viride based on our experience with it in Decatur.

REFERENCES

1. Willson, J. R.: Am. J. Obst. & Gynec. **52**:273, 1946.
2. Assali, N. S.: J. Mich. State **51**:586, 1952.
3. Assali, N. S.: Am. J. Obst. & Gynec. **60**:387, 1950.

4. Baird, W. W., Assali, N. S.: Am. J. Obst. & Gynec. 62: 1093, 1951.
5. Garber, S. T., Assali, N. S., Kistner, R. W., and Prystowsky, H.: Am. J. Obst. & Gynec. 60:315, 1950.
6. Finnerty, F. A., Jr.: New England J. Med. 246:646, 1952.
7. Alban, E. J., Jr., Dennis, M. S., and Swanson, C. N.: Am. J. Obst. & Gynec. 64:1083, 1952.
8. Finnerty, F. A., Jr., Fuchs, G. J., Jr.: Am. J. Obst. & Gynec. 66:830, 1953.

Acute Intestinal Obstruction

Irving Rudman, M.D., Frankfort

ACUTE intestinal obstruction is encountered frequently and invariably presents difficult problems in surgical management. In the older individual especially, therapy often is disappointing.

In 1912, intravenous saline was found to prolong life in animals suffering complete duodenal obstruction but such therapy was of far less benefit when the obstruction was in the lower ileum. The significance of this observation went unnoticed until 1925, when Wangensteen postulated that the dangers of low obstruction were intestinal distention with consequent seepage of fluid, bacteria, and toxins into the peritoneal cavity. Thereafter Payne and Wangensteen introduced the concept of suction decompression.

The next significant improvement in management took place about 1944, when three important contributions were made. The first was penicillin, ushering in the antibiotic era. Second was the increasingly liberal and intelligent use of intravenous electrolytes and whole blood. Third was the growing realization that suction decompression should be considered primarily as an adjunct in treatment, with surgery as the definitive therapy.

The material for this study was derived from the surgical service of a large municipal hospital. Included were all cases of complete obstruction treated by emergency surgery between July 1942 and July 1944 (54 patients); and from July 1951 to July 1953 (69 patients).

Twenty-five years ago, as reported by McIver in the Archives of Surgery (volume 25), external hernia accounted for almost one-half of all cases of intestinal obstruction. Adhesions were responsible for 20 percent and neoplasms for only 10 percent of that series of patients.

Figure 1.
Causes of Intestinal Obstruction

	Years 1942-1944		Years 1951-1953	
	No. Patients	%	No. Patients	%
External hernia	15	28	10	14
Adhesions	14	25	28	41
Neoplasms	16	30	18	26
Volvulus	5	9	5	7
Miscellaneous	4	8	8	12

Figure 1 summarizes the various causes of acute obstruction in 123 patients included in the present study. External hernia no longer ranks first but adhesions account for almost one-half of all cases. As hernia has declined in importance, neoplasms and adhesions have become the predominant factors in this disease. Presumably the advance in life expectancy accounts for the rise in neoplasms; and the growing volume of elective hernia repairs plays a part in the drop in incidence of obstructing external hernia.

The current status of intestinal obstruction is strongly influenced by the high incidence of adhesions. Figure 2 lists the various causes of adhesions in the two series. A decade ago, obstruction due to adhesions occurred most often in the convalescent postoperative period but in

Figure 2.
Incidence of Adhesions

	Years 1942-1944		Years 1951-1953	
	No. Patients	%	No. Patients	%
Early postop.	6	42	5	18
Late postop.	4	29	18	64
No previous surg.	4	29	5	18

Formerly senior surgical resident Meyer Memorial Hospital and University of Buffalo Medical School, Buffalo, New York
From the Hedges Clinic, Frankfort, Illinois

the current series, most cases occurred long after surgery. This distinction is of importance when correlated with mortality statistics.

The overall mortality rate in both series was approximately 30 per cent. This discouraging figure is not unusual for any series in which geriatric patients predominate and cases of carcinomatosis with obstruction are not excluded. The average age of the 123 patients in this study was 58. In the 1942-1944 group, 24 percent were older than 70 and four per cent were older than 80. In the 1951-1953 series, 32 per cent were older than 70 and 13 per cent were older than 80. The higher percentage of extremely old patients in the current group may account for the failure of mortality statistics to improve in the past ten years.

Figure 3 compares the mortality rate of the two series under discussion. The results of

Figure 3.
Mortality Rate in Major Groups

	Years 1942-1944		Years 1951-1953	
	Deaths	%	Deaths	%
External hernia	1	7	0	0
Adhesions	5	36	7	25
Neoplasms	7	44	7	42

surgery for external hernia are interesting. There were four femoral hernias in the 1951-1953 group and all contained gangrenous bowel requiring resection. There were no deaths. This 100 per cent incidence of gangrene in femoral hernia lends striking emphasis to the precipitous course of the disease and the urgency for immediate surgery.

The overall mortality rate in obstruction due to adhesions has fallen somewhat in the past decade. (Figure 4). This is probably due to a

Figure 4.
Mortality Rate in Adhesions

	Years 1942-1944		Years 1951-1953	
	Deaths	%	Deaths	%
Early postop.	3	50	2	40
Late postop.	1	25	3	16
No previous surg.	1	25	2	40

redistribution of cases, as was mentioned previously. The majority now obstruct long after surgery rather than in the immediate postoperative period. When surgery is required to correct intestinal obstruction in the early postoperative period, the mortality is still prohibitive.

It is interesting to speculate on the significant shift of cases from the convalescent postoperative to the late postoperative group in the past ten years. An analysis of the records of patients with obstruction during surgical convalescence indicated an element of clinical peritonitis in virtually all cases. The majority were associated with intra-abdominal abscesses. The introduction of antibiotics may well have reduced the incidence of postoperative peritonitis to some extent, thus contributing to the decline in frequency of early postoperative obstruction.

In listing obstruction due to neoplasms, all cases of carcinomatosis were included. If these "hopeless" cases were excluded the mortality rate in this group would be 20 per cent rather than 40 per cent.

This leaves to be mentioned obstructions due to volvulus, the closely related internal hernia, and adhesive bands without previous surgery, all of which present identical problems. Gangrene develops rapidly and, as a result, mortality is high. There is no diagnostic hint from previous disease or surgery. For this reason, surgery may be delayed while efforts to make a diagnosis are in process. It is clear that in this category, improvement in therapy can result only from earlier surgery and the dictum "When in doubt, operate" seems appropriate.

This concludes the major features of the study. What follows may be termed incidental intelligence. First, in the treatment of left colon obstruction, no superiority was demonstrated for either cecostomy or transverse colostomy. The immediate results of treatment of acute obstruction and the later results of resection did not seem to be influenced by the type of decompression selected.

Preoperative sigmoidoscopy should be performed in every case of bowel obstruction, no matter how obvious the diagnosis may appear. Two deaths in this series occurred in patients who were operated upon for sigmoid obstruction due to inguinal hernia, while a distal obstructing rectal carcinoma remained undetected because sigmoidoscopy was not done.

Flat and upright abdominal x-ray films are invariable components of the diagnostic workup of acute obstruction. However, greater reliance is placed on X-ray interpretations than their accuracy warrants. In this series, the X-ray

failed to identify mechanical obstruction in 32 per cent of the cases. On theoretical grounds, it might be expected that x-ray diagnosis would be more difficult when gangrene is present. This is confirmed by the statistics which show an error of 45 per cent in cases of gangrene, as compared with 28 per cent when gangrene was absent. Moreover, diagnosis of large bowel obstruction by x-ray is far more accurate than that of small bowel obstruction. There was an error of only 12 per cent in preoperative x-ray identification of large bowel obstruction.

‹‹‹ ›››

A New Agent for Control of Dermatological Problems in Nurseries

Herbert E. Schmitz, M.D. and Margaret Scannell, M.D., Chicago

RECENT studies by Farquharson et al[1] and Lipschutz and Fitti[2] in the use of antibacterial detergents for the control of common nursery skin disorders have shown the superiority of these agents over ordinary soaps. In view of our responsible association with the maternity services in several institutions, we felt called upon to confirm these results by clinical trial. Farquharson[1] and Abernathy[3] reported the effect of using the common surgical prepping agent, pHisoHex. Lipschutz and Fitti[2] employed a similar preparation, Tod'l*, with a lower percentage of the antibacterial agent to determine if its properties were beneficial. In our study, we employed this latter preparation.

The purpose was to determine whether a synthetic, antibacterial, cleansing agent — with a reported pH value on the acid side similar to that of normal skin — would be therapeutically or prophylactically useful in staphylococcal infections and certain other skin eruptions that occur at times in epidemic proportion in neonatal wards. The product employed is an emulsion of a sulfonated ether, petrolatum, and wool fat cholesterols containing 0.5 per cent of hexachlorophene. The pH value is slightly acid in contrast to ordinary soaps which are always alkaline.

METHOD OF CONDUCTING THE STUDY

The study was made in the nurseries of Lewis Memorial Maternity Hospital and Saint Vincent's Home and Maternity Hospital. Two hundred fifty babies were washed daily with the above described product and another 250 were soaped as a control. In control groups, a plain, bland, unperfumed cake soap was used. The scalp, face, and body were washed daily. The buttocks and groin were washed with Tod'l with each change of diapers and similar cleansing was carried out with soap on the control group.

Included in our series were infants and children with normal healthy skin and those showing infection of one type or another, diaper rash or miliaria. The object in cleansing normal skins with either soap or Tod'l was to compare the effects of a common soap (alkaline) with a soapless, nonalkaline, nonkeratolytic, antibacterial

From the Newborn and Pediatric Services of Lewis Memorial Maternity Hospital and St. Vincent's Infant and Maternity Hospital

*Manufactured and supplied by The Centaur-Caldwell Division of Sterling Drug, Inc.

sudsing synthetic detergent. The response of normal as well as abnormal skin was studied and recorded as well as the dates of beginning or ending infection or other abnormal condition.

RESULTS

In the nurseries of two maternity hospitals under our direction, where we used plain bland, unperfumed soap, 276 cases of common skin disorders, such as impetigo, diaper rash or miliaria had occurred between July 1, 1947 and June 30, 1952. The Tod'l study was conducted from July, 1952 to June 1953.

The skin of the "normal" group using Tod'l appeared to be somewhat cleaner and softer than the skin of the "normal" group on whom common soap was used. Over the time of the study, the daily use of soap seemed to cause more dryness and roughness of the skin than synthetic detergent did. This was attributed to the absence of keratolytic action of the latter.

Superficial infections persisted longer when soap was used for cleansing and cleared earlier when Tod'l was used daily for over-all washing.

In the study group, 17 cases (6.8 per cent) of skin infection developed, only five of which required additional specific therapy. In the control group there were 31 cases (14 per cent) of varied skin infection such as impetigo, diaper rash or miliaria.

SUMMARY

An antibacterial synthetic detergent used with water routinely on the entire body surface of infants and children apparently had curative as well as prophylactic effect on staphylococcal infections of the skin.

The routine use of this detergent had value in the prevention and treatment of miliaria and diaper rash.

The preparation did not cause irritation of any kind and sensitivity to the product did not develop.

We are of the opinion that the technic used may also have prevented recurrence of an epidemic of impetigo as in previous years.

REFERENCES

1. Farquharson, C. D., Penny, S. F., Edwards, H. E., and Barr, Elizabeth: The Control of Staphylococcus Skin Infections in the Nursery. Canad. MAJ, 67:247, Sept., 1952.
2. Lipschutz, Arthur, and Fitti, R. M.: New Antibacterial Detergent for Common Skin Diseases in Children. Arch. Dermat. & Syph., 68:83, July, 1953.
3. Abernathy, R. A., Jr.: The Incidence and Control of Pustules in the Nurseries. Brooklyn Hosp. J., 10:140, No. 3, 1952.

‹ ‹ ‹ › › ›

The shift to the city

The shift from agricultural to nonagricultural pursuits is one of the hallmarks of American economic history of the last several generations. This story can be recited without too many statistics as follows:

In 1870, there were about 7 million farm workers; 6 million nonfarm workers. In 1950, there were about 7 million farm workers; 53 million nonfarm workers. Today, we have the same number of farm workers as in 1870, but producing food for a populations nearly four times as large and also shipping extra farm products to other nations. In contrast, the growth ot industry and business has been overwhelming. Accompanying this trend has been the growth of great cities and the urbanization of the American populations. *Seymour L. Wolfbein, Ph.D. New Patterns of Planning in a Changing Scene. Pub. Health News. N.J. State Dept. of Health. April* 1955.

The Management Of STASIS DERMATITIS

Myron H. Kulwin, M.D., Champaign

THE clinical phenomena associated with venous stasis in the lower extremities and the sequellae thereof are among the most common of entities seen in the practice of medicine. It has been estimated that 10 to 17 percent of the population are afflicted with varicose veins and their complications.[1]

Stasis dermatitis may be defined as that inflammatory process which occurs on the skin of the lower limbs, associated with chronic venous insufficiency in those parts. It must be differentiated from all other dermatoses which may involve the legs, from other systemic disorders which may produce peripheral edema, and from edema and hemosiderosis associated with cardiac decompensation. It is interesting to contemplate the fact that this condition is limited to the legs and does not occur in the arms. This disparity has been explained by the assumption that man has not yet been walking on his hind legs long enough to become fully adapted to the upright position.

It is important to understand the pathogenesis of the stasis syndrome and its complications in order that a fundamentalist approach to treatment may be adopted.

Such venous insufficiency may arise as a result of obstruction to one of the main veins of the extremity, due to thrombophlebitis, neoplastic invasion, or extravenous intra-abdominal pressure. It may also occur as a result of valvular incompetency of the iliofemoral vein resulting from thrombophlebitis without permanent obstruction. There is no doubt but what certain undetermined hereditary factors play a role in the predisposition of certain individuals to develop varicose veins. It has been estimated that 43 to 49%[1,2] of patients have a familial history of the disease.

From the Department of Dermatology, The Christie Clinic, Champaign, Illinois.

Presented before the Section on Dermatology, 114th Annual Meeting, Illinois State Medical Society, Chicago, May 19, 1954.

The loss of circulatory equilibrium attendant to chronic venous insufficiency inaugurates a train of pathological events which may include edema, non-inflammatory skin changes, inflammatory changes in the skin, changes in the subcutaneous tissue, muscle, bone and joints, superficial venous thrombosis or rupture, ulceration, or changes secondary to ulceration. The pathogenesis of the cutaneous changes—stasis dermatitis—is usually explained on the basis of chronic passive congestion of the skin and subcutaneous tissue, which results from venous stasis in the varicose superficial vessels.

Equally important, however, are certain changes that take place in the cutaneous arterioles in patients with chronic venous insufficiency, and these must also be considered from the standpoint of therapy. We have studied the cutaneous vascular changes in a series of patients in whom a clinical diagnosis of chronic venous insufficiency had been made.[3] Of thirty biopsy specimens in which a study of cutaneous arteriolar structure was made, twenty-five showed variations from normal, and, of these, eight were from normal appearing skin. This would bear testimony to the fact that these arteriolar changes are not secondary to inflammatory changes in the skin, but rather, are of a primary nature. Of nine patients with chronic venous insufficiency and normal appearing skin, only one showed no evidence of arteriolar pathologic changes. The more commonly seen structural abnormalities in the arterioles were intimal proliferation, fragmentation and reduplication of the internal elastic membrane, endothelial hyperplasia, and medial hypertrophy. It is therefore evident that arteriolar changes and their pathophysiologic sequellae must be considered from the standpoint of therapeutic rationale.[4]

The primary principle to be followed in the treatment of dermatitis of the lower legs, due to chronic venous insufficiency, is to correct the underlying anatomic abnormalities, whenever

possible. This is done, of course, by proper surgical procedures such as stripping or ligating the veins at fault. In cases of long standing, however, these procedures are not always entirely adequate to correct the situation. We have, in our Clinic, performed lumbar sympathectomies on some of these patients who had previously failed to respond therapeutically to conventional vein procedures. Based on the concept of primary arteriolar pathology, and by thus improving the peripheral arterial circulation, this procedure has helped many additional patients.[5]

Proper dermatological treatment is a mandatory accompaniment to corrective surgical procedures and, in practically all instances, two goals are set. The first is to improve circulatory return from the affected limb and the second, to correct any secondary eczematous changes which have occurred.

To improve circulatory return it is necessary to prevent edema formation, so that an already impaired venous and lymphatic system is not overburdened. When edema is present, it is an early danger sign, inasmuch as it will occur when the amount of collected tissue fluid increases the limb volume but 8 percent.[6]

Complete rest and elevation of the affected limb is the method of choice to reduce and prevent tissue fluid accumulation. We have found a convenient rule of thumb to go by in our instructions to patients: the ankle should be kept slightly higher than the hip.

When edema has been reduced, it is then necessary to maintain the subcutaneous tissue in a non-edematous condition. This is best accomplished by frequent horizontal rest periods and the constant use of an elastic roller bandage or stocking on the affected limb. A position of static dependency of the leg should be avoided. Walking is better than standing, because the pumping action of the muscles helps partially to overcome the circulatory stasis. The patient should also avoid postural and clothing habits, such as crossing the legs and the use of elastic garters, which may further impair an already inadequate circulation.

Frequently, continued observance of the aforementioned hygienic measures alone are adequate to arrest and control the progression of the varicose-symptom-complex.

In those cases in which true eczematization of the affected skin areas has already occurred, treatment measures must be directed more specifically at the skin. In the presence of an acute weeping eczematous dermatitis, the patient should be put to bed and mild, soothing applications such as compresses of boric acid solution, Burow's solution or aluminum subacetate solution should be employed. If there is evidence of secondary infection, such as diffuse cellulitis or thrombosis of superficial venules, this treatment should be accompanied by systemic antibiotic therapy. In chronically eczematized cases, when lichenification is a prominent feature, the use of topical stimulants such as salicylic acid ointment or a tar-containing preparation is indicated. These may be accompanied by the judicious use of x-ray therapy, in small doses, to hasten involution of the eczematous process and relieve the often severely distressing pruritus.

Particular mention should be made of the use of steroid preparations such as cortisone, hydrocortisone, and ACTH. One must be scrupulously careful to avoid their use wherever a secondary bacterial infection is present or suspected to be present. Their use may convert a mild superficial pyoderma into a fulminating, rampant, rapidly spreading pan-cellulitis and result in systemic dissemination of the infection. We have seen this occur in two patients in each of whom steroid ointments had been applied to apparently banal eczematous lesions.

Finally, a word of caution should be said about employing overly intensive dermatological treatment in cases of long standing. Such aggressive therapeusis may result in the appearance of a generalized eczematous sensitization reaction which, eventually, may become more of a problem both to patient and physician than was the original primary stasis dermatitis.

Generally speaking, the treatment of the stasis syndrome and, in particular, stasis dermatitis, should be based on sound logic and directed, whenever possible, at the correction of underlying circulatory defects. The patient must be made to understand that his problem is one with which he may have to contend for many

years. However, with proper care and hygiene, there will be a minimum of discomfort and disability.

BIBLIOGRAPHY

1. Larson, R. A., and Smith, F. L.: Varicose veins; evaluation of observations in 491 cases. Proc. Staff Meet., Mayo Clin. **18**:400-403 (Oct. 20) 1943.
2. Miller, R. P., and Sparrow, T. W.: The pathogenesis, diagnosis and treatment of varicose veins and varicose ulcers. North Carolina M. J. **9**:574-579 (Nov.) 1948.
3. Kulwin, Myron H.: Blood vessels of the skin in chronic venous insufficiency. Thesis, University of Minnesota, 1949.
4. (a) Kulwin, H. H., and Hines, Jr., E. A.: Blood vessels of the skin in chronic venous insufficiency. Arch. Derm. & Syph. **62**:293-304 (Aug.) 1950.
   (b) Kulwin, M. H., and Hines, Jr., E. A.: Blood vessels of the skin in chronic venous insufficiency. Circulation. **2**:225-229 (Aug.) 1950.
5. Christie, James M.: personal communication.
6. Drury, A. N., and Jones, N. W.: Observations upon the rate at which edema forms when the veins of the human limbs are congested. Heart **14**:55-70 (April) 1927.

Disability and labor

Our added longevity has given our population many added manyears of potential working life. This is a matter of crucial importance in today's emphasis on our manpower needs, especially in terms of national security. But the manpower expert knows very well that attrition from the American labor force occurs not only because of death but also because of disability. The disabling effects of chronic illness represents the major threat to the consummation of the added work potential of trends in life expectancy and labor force. That this threat is real is known by every practitioner in this field. As Dublin and Lotka have shown, we make a rather poor showing in comparison to other countries in the world when it comes to mortality in the middle and older years — especially in the cardiovascular-renal diseases and diabetes. Programs looking toward the prevention and control of chronic illness and the rehabilitation of the disabled will therefore make a very direct contribution not only to the general and economic well-being of the individual and his community, but to the national security as well. *Seymour L. Wolfbein, Ph.D. New Patterns of Planning in a Changing Scene. Pub. Health News, N.J. State Dept. of Health, April* 1955.

The dramatic disappearance of Pott's disease (tuberculosis of the vertebrae), the precipitous drop in human brucellosis in urban populations, and the decline of other milkborne human diseases, including typhoid fever, summer diarrhea, diphtheria, and streptococcal infections, are self-evident. Pasteurization cannot take credit for all of the decline of those diseases among men, but it has been a sizable factor and in some cases the most important single public health practice. James H. Steele, D.V.M., Pub. Health Rep., Nov., 1954.

COOK COUNTY HOSPITAL CASE RECORDS

Foreign Body ("Fish Bone") Granuloma

Eli T. Samet, M.D.* and Samuel J. Fogelson, M.D., F.A.C.S., Chicago**

W.G., a 31 year old colored male, entered Cook County Hospital on October 20, 1954 with the complaints of "cramping abdominal pain" to the left of the umbilicus for about three weeks. The pain was intermittent from twenty four hours after a two day drinking bout, during which he ate one meal, consisting of a fish dinner. For two weeks prior to admission, he had no bowel movements but had passed gas per rectum. No chills or radiation of abdominal pain. Since this episode, his diet consisted of "soft foods and liquids" and, one day prior to admission, he ate soft boiled eggs and had an immediate non-bloody emesis of ingested food.

Past history revealed W.G. had two previous admissions to medical wards at the Cook County Hospital, June 15 and November 2, 1951. His primary complaints were "headache and nosebleeds" of two weeks duration. At that time, a fluctuating hypertension and an unexplained eosinophilia were present. On each occasion, a workup for the eteology of the hypertension and eosinophilia was negative and the discharge diagnosis was "essential hypertension". The treatment was supportive.

Positive physical findings on present admission on October 20, 1954 revealed a thirty-one year old, well developed, well nourished, colored male who appeared acutely ill. BP165/95; Pulse 100; Temp 103° rectally. Chest—negative. Abdomen—flat when measured from xyphi-pubic angle. A tender mass, about five cm. in diameter, smooth, moveable only slightly with respirations was palpable just to the left and slightly above umbilicus. The bowel sounds were considered normal and there was no rebound or tenderness except over the area of the mass. No lymphadenopathy. Rectal examination revealed no stool. Urinalysis—trace of albumin, otherwise negative. NPN 30; Creatinine 1.1; Blood Sodium 130; Chloride 95; Potassium 3.3; CO_2 combining 50; Blood Amylase 8; Urinary Amylase 32; Hemoglobin 76%; WBC 10,500; Eosinophils 7, with a normal differential; Fasting Blood Sugar 110.

Emergency x-rays of chest and abdomen were negative. Barium enema (Figure 1) revealed the entire large bowel readily filled with barium. Left part of the transverse colon was narrowed and seemed to be displaced superiorly by a rounded mass at the level of lumbar vertebra 3. The mucosal pattern appeared normal.

It was elected to treat the patient conservatively for the immediate present and he was placed on atropine, penicillin, continuous Levine suction, intravenous fluids, oil and enema routine, and close observation.

Approximately ten hours after admission, on October 21, 1954, the patient's condition had so markedly improved that he desired to sign

**Resident in General Surgery, Cook County Hospital, Chicago, Illinois*

***Attending Surgeon, Cook County Hospital, Chicago, Illinois*



Figure 1. Barium enema.



Figure 2. Barium meal.

a release and go home. Examination at that time revealed the tenderness over the abdominal mass to be markedly diminished, altho the size remained the same. The rest of the abdomen was soft and bowel sounds were normal. BP 140/80; temp 100° rectally; pulse 90; CBC 8000; eosinophils 7, with a normal differential; serum amylase 8; urine amylase 8; urinalysis—negative. Tap water enema returned several small segments of dark brown stools which were benzedine negative, and some mineral oil.

Barium meal (Figure 2) on October 22, 1954 was reported as demonstrating pressure on the greater curvature of the stomach by an extrinsic mass. However, lateral views of the barium meal and enema showed only upward displacement of transverse colon but no anterior displacement. The patient was afebrile and subjectively improved from October 22nd on. The abdominal mass remained but tenderness was no longer present. He was uncooperative and desired to go home because "I feel good". He was induced to remain in the hospital and a series of tests were performed to attempt to rule out abdominal Hodgkins disease, pancreatic cyst, pheochromocytoma, paraganglioma, omental cyst, retroperitoneal lymphoma, tumor of large or small bowel, trichinosis, etc.

KUB and intravenous pyelograms were normal. Urine concentration-dilution was 1000-1020, glucose tolerance, histamine, cold pressor, sodium amytal, regitine tests were all negative. Repeated stools for ova and parasites were negative. The patient refused muscle biopsy and sternal marrow puncture examinations.

His bowel was prepared with sulfasuccidine preoperatively and on November 1, 1954, W.G. was explored under general endotracheal anesthesia. A long left paramedian incision was made. A five centimeter tumor mass was seen just to the left of the mid-transverse colon with an adherent loop of jejunum to the colon. The remainder of the abdominal organs were normal with the exception of a millimeter sized nodule in the liver. No other nodes were evident. Three inches of transverse colon and three inches of jejunum on either side of the tumor was resected intact with the tumor mass. An end to end anastamosis between the two ends of the transverse colon and jejunum was performed with two layers of interrupted black silk. The nodule in the liver was removed by excision biopsy.

Examination of the specimen demonstrated the mucosa of the large and small bowel to be normal. An indurated mass, containing omentum, measuring 5 x 5 centimeters was attached to the serosal surfaces of the jejunum and transverse colon. Embedded in the mass was a foreign body (fish bone) measuring two centimeters in length.

Microscopic section was reported as a foreign body granulation tissue surrounding a fishbone with had undergone some necrosis. The liver biopsy was reported as normal liver parenchyma with small number of round cell infiltration.

The patient, W.G., had an uneventful postoperative course. His chemistries and peripheral blood studies were completely normal on November 5, 1954. Eosinophil count was four and BP 130/70.

This case was instructive to us because of the problem of differential diagnosis both preoperatively and at the operating table.

‹‹‹ ›››

Osler's conviction

If Osler had been gruff, secretive, and unforthcoming as a human being, he still would have left a mark on the history of medicine. But it was for personal qualities and unmediated disclosures of himself that men loved and followed Osler in life and after death; and he for his part had almost a mystique of personality and warm human relationships. He was and meant to be an ethical figure, who saw in medicine not only a means of healing the sick but of giving "unity, peace, and concord" to the healers. For him it was left to speak of the local medical society in the same tone that other men had reserved for the regiment and the congregation — a place where all selfish wills must be yielded up and animosities put aside. For a man who consistently struck this note, full-time was a moral calamity, a disastrous impoverishment of the clinical man's right and duty to be implicated in the whole community of physicians. A man who stood aside from the process of humanizing and being humanized by the friction of personal contacts might be a scientist but never a doctor. The increasing application of science to medicine left Osler unshaken in his conviction that medicine itself must remain an art and distinctively the art of establishing personal rapport between the physician and the patient. *Donald Fleming. The "Full-Time" Controversy. J. Med. Education, July* 1955.

‹ ›

Discouraging

Chronic alcoholism is a good example of a public health problem that has bogged down because of negative reactions. Yet, even the people working most intimately with this problem have no ready measure of the effectiveness of their efforts to change the community's attitude toward it. *Berwyn F. Mattison, M.D., M.P.H. Epidemiological Techniques and Data in Planning Public Health Programs. Pub. Health Reports, July* 1955.

CASE REPORTS

Pulmonary Embolism in Poliomyelitis

J. Keller Mack, M.D., Springfield

AMONG the manifestations of poliomyelitis are: weak and inactive extremities, vasomotor disturbances, and, in the severe forms, respiratory difficulties. Many of the sicker patients with this disease are subjected to intravenous injections. One could surmise that the factors mentioned above might predispose to pulmonary embolism in an appreciable number of patients. This reasoning is not borne out by the reported facts. In a review of the literature, only two instances could be found in which pulmonary embolism was mentioned as accompanying bulbar poliomyelitis in causing death. This fact is even more remarkable when one considers the extensive amount of research done on poliomyelitis.

The Minnesota Poliomyelitis Research Commission[1] reported a single case of pulmonary embolism in a patient with bulbo-spinal disease. No details were given.

Fowler,[2] in the course of a description of eleven cases of poliomyelitis, mentions a 38 year old man who died suddenly on the 14th day of pulmonary embolism. Details are not given but autopsy showed clots in the right ventricle and both branches of the pulmonary artery. Small fragments of ante mortem clot were found adhering to the walls of the right popliteal vein.

Because of the rarity of the occurrence of pulmonary embolism in poliomyelitis, the following two cases are reported. It is of further interest to note that they occurred in the same hospital within a week of each other.

Case 1. E. C. S. Aged 14 years, was admitted to the hospital October 14, 1952 with the history that she had become ill on 10/10/52 with headache and fever. She had been unable to swallow during the day of admission. A spinal fluid examination done outside this hospital, revealed 138 cells, the majority being lymphocytes, and a protein content of 56 mgm%. There was no other significant history. She had been previously well.

Physical Examination: Temperature 102°. She was acutely ill and she occasionally had jerking motions of her arms, although these were not real convulsions. Her face was suffused but not cyanotic. The voice was nasal and thick. She could count to nine without taking another breath. There was much mucus in the throat, but she could clear it, and was able to bring up saliva. The palate moved

slightly, but not well. The neck and back were quite stiff. Heart and lungs were negative; pulse, good; blood pressure, 110/80. Extremities were moved very well but it was reported that the arms were not moving as well as they did on admission.

Impression: Bulbar poliomyelitis, but it was decided to defer tracheotomy.

Progress: She was given conservative treatment and began to improve. The next day her temperature was lower, the blood pressure was 124/90. She did not appear to be any worse as far as swallowing was concerned, she could still bring up mucus, but the voice was weak and hoarse. Other cranial nerves seemed to be normal. The poor voice was thought to be due to tenth nerve involvement.

Blood count was normal and urinalysis normal. The blood pressure continued to run about 120/85 for several days. She gradually improved so that on the sixth hospital day, the temperature was normal. She was given intravenous fluids to maintain a moderate intake. These fluids were given intermittently and not by continuous drip.

A Foley catheter had to be placed in the bladder for several days because of voiding difficulty. On October 21, (the 7th. hospital day) a polyethylene tube was inserted into the stomach and she was fed through this. She still had to be suctioned but was able to get up some mucus by herself.

During all this time she was moving about very well in bed and could move all extremities. Muscle examination by an orthopedist on October 26 showed: upper extremities good, trunk muscles good except for some weakness of the abdominals, leg muscles good except for some poor coordination of the right leg with some spastic extensor weakness. However, she was able to move her legs, which she did frequently.

During the early morning hours of October 25 she complained of pain in the legs but this was not considered unusual. She had hot packs to the legs for forty-five minutes later in the morning, and these were repeated in the afternoon because of pain.

The stomach tube remained in place and she retained her feeding of liquids very well.

During the early morning hours of October 26 she again received aspirin for pain in the legs. At 9:00 AM she was talking and active, according to the nurse's notes. At 10:00 she complained of having pain in the right chest, did not feel well. This was followed by vomiting. She was examined but nothing definite was found except a moderate amount of mucus in the nose and throat. At 11:00 AM she began to cough and her color was poor. She was given oxygen. At noon her temperature went up to 102°. Examination at 1:00 PM revealed her to be moderately cyanotic in spite of oxygen. The extremities appeared spastic and she was chilling; her skin was hot and dry. There was some impairment of resonance and absence of breath sounds at the base of the right lung. The patient coughed frequently, had a peculiar hoarse type of cough but the voice seemed normal.

She was given three sprays to the pharynx with 2% pontocaine in preparation for bronchoscopy for possible aspiration of vomitus. She rather suddenly had three generalized convulsions and expired, did not respond to stimulants and resuscitative measures.

The impression at that time was possible cerebral and pulmonary embolism. She expired at 1:30 PM October 26th, 1952.

Autopsy Findings: There was hemorrhagic exudate around both nares and mouth. There was a moderate amount of blood and bloody fluid in the bronchial passages. The pulmonary arteries were opened in situ and no clots were noted. The bronchial mucosa was reddened due to presence of blood. Both lungs were quite heavy and edematous and the right and left lower lobes showed numerous purplish areas on the surface. These continued on section and measured from a few millimeters up to 3 centimeters in diameter and appeared quite firm and deep red in color.

The heart was normal except for a dilated right ventricle. The muscle of the right ventricle averaged 1-2 millimeters, the left ventricle averaged 1 centimeter in thickness. One small clot 4 millimeters in diameter was found in the lumen of the right ventricle.

The brain was soft. A few pink areas were noted in the pons and in the medulla and upper cord. There was no excess fluid and no areas of hemorrhage. No other abnormalities were noted and no source of thrombus formation could be found.

Microscopic Examination: Sections from the upper cervical cord showed diffuse parivascular cuffing in the anterior horn areas with complete loss of structure involving many nuclei. A few nuclei still remained with degenerative changes. One side was more involved than the other. The meningeal vessels were dilated. In the section from the pons a few parivascular round cells were noted. In one of the sections from the medulla numerous perivascular round cell focci were present.

Heart-Muscle fibers showed poor staining reaction and were moderately separated.

Lungs- A few of the bronchi showed round cells in the wall. The alveoli frequently contained fluid and blood cells in large numbers. The vessels were mostly dilated and here hemorrhagic necrosis was present. Moderate edema had occurred elsewhere. (Figure 1) shows the

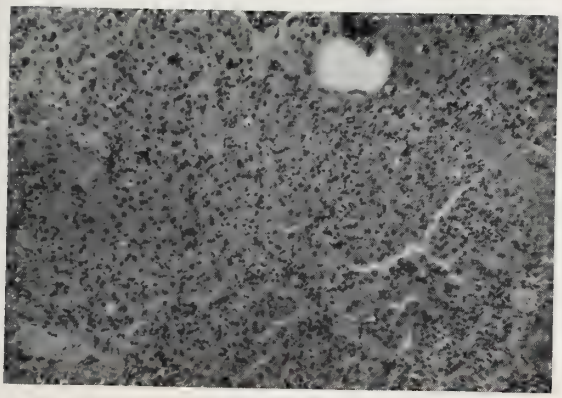


Figure 1

edge of an infarcted area depicting edema and infiltration of red cells.

Adrenals- Marked edema. Lipoid depletion of cortex. Degenerative changes throughout. One small cortical adenoma noted.

Other organs were essentially normal on microscopic examination.

Final Diagnoses:

1. Bulbar Poliomyelitis.
2. Pulmonary embolism.
3. Pulmonary edema.
4. Dilated right heart.
5. Cyanotic congestion of all organs.
6. Shock.

Cause of Death: Pulmonary embolism in acute bulbar poliomyelitis.

Autopsy performed by
Dr. H. Ivan Brown.

*Case 2. C. E. I. Aged 30 years, was admitted October 5, 1952.

Chief Complaint: Stiffness of neck, weakness of back and shallow breathing.

Present Illness: One week before admission to the hospital, the patient had a gastrointestinal upset, and symptons of a common cold. On the day before entrance, the patient complained of backache, chills, and temperature. On the following morning the stiffness of the neck was severe, respirations were slightly shallow, and abdominal reflexes suppressed. He was unable to walk at that time.

Physical Examination: Showed that the patient was apprehensive, flushed and seemed to talk with some effort. Respirations were increased and seemed to be more shallow than earlier in the day. Nose-flaring of nares with respiration. Mouth-dry, membranes clear, gag reflex present. Neck-Moderately stiff. Lungs-Respirations shallow. Heart-Rapid, regular, no murmurs.

Neurological Examination: Abdominal reflexes diminished, cranial nerves negative. Knee jerks and ankle jerks diminished on the right side. The remainder of the examination was essentially negative. Lumbar puncture revealed a slightly hazy fluid with a cell count of 192; 72% polys, 28% lymphocytes; total proteins, 150 mgm%. Blood count showed a WBC of 16,-650, otherwise normal. Urinalysis showed a 2 plus albumin and 2 plus acetone. There were 3-4 red cells per HPF on microscopic examination.

Progress: On the day of admission the patient became progressively worse although his temperature was only 100. He developed difficulty in swallowing and mucus accumulated in the throat. He became cyanotic. A Foley catheter was inserted into the bladder because of inability to void. Large amounts of thick mucus were being suctioned from the nose and throat, so a tracheotomy was done. He got some relief from this procedure, but he was still cyanotic at times. His temperature went up to 102° and the blood pressure was 158/110. He was given bulbar polio treatment, including intravenous glucose in saline. His condition remained only fair. Tryptar solution was used in the tracheotomy tube to thin out the

*Case 2 is presented with the kind permission of Dr. A. A. Manson.

mucus. The next day he had to be put into a chest respirator, and temperature remained elevated around 102°. On October 9, 1952 petechial spots were noted on the back. A blood count was normal, showing 15,400 WBC; prothrombin time, 14 seconds, 100% of normal; platelet count, 245,000; bleeding time, 1 minute, 5 seconds; clotting time, 3 minutes, 40 seconds.

On October 10th., the NPN was 52 mgms.%; the chlorides, (as sodium chloride) 533 mgms.%; CO_2 combining power, 53.2 vols.%.

Intravenous fluids were given continuously; the blood pressure continued to run around 140/90. Cold sheets were applied to the extremities for relief of temperature. It was necessary to continue to suction from the tracheotomy tube, he required oxygen, and his temperature did not go below 100. Otherwise his heart and lungs were normal and his general appearance was good. He received passive exercise to the legs. On October 13, 1952, he complained of pains in the legs.

X-ray of the chest showed a slight pneumonitis at the right base. Temperature began to run higher, up to 102 and even 104; at times he was irrational and confused. From time to time he was given positive pressure in the tank respirator. On October 15th. he was able to swallow a little orange juice. Intravenous fluids had been given up to this time but now a polyethylene tube was inserted into the stomach and he was fed thru this. Blood tinged mucus was sometimes suctioned from the tracheotomy tube. By October 19th. the temperature had risen to 105°, the systolic blood pressure varied between 178 and 90. He became comatose and required oxygen continuously. When oxygen was stopped he would become cyanotic. Blood pressure dropped and intravenous fluids were resumed. On October 20, 1952, the patient became more cyanotic and expired.

Autopsy Findings: The lungs were very heavy. The right lung weighed 800 grams. The left lung weighed 1100 grams. There was a small amount of aeration in the anterior portion of the right upper lobe and also the left middle lobe. The remaining lung fields were very edematous and of a pinkish red color on section. In the lower left lobe there were two firm areas averaging 5 centimeters in diameter. On section these were quite sharply demarcated and hemorrhagic on cut surface. The entire pulmonary artery was filled with partially organized tubular type of blood clots averaging up to 5 centimeters in length and 1 centimeter in diameter. There was a small amount of hemorrhagic fluid in each pleural cavity.

The heart weighed 475 grams and showed a very soft flabby musculature. The coronary vessels were patent and normal throughout. The valves were normal and other gross findings essentially normal. Examination of the brain was not permitted.

Microscopic Examination: Lungs- Large areas of hemorrhagic necrosis; partial atelectasis; edema; foci of broncho-pneumonia; apparently aspiration type. Two areas of infarction were found. (Figure 2) shows an area of infarc-

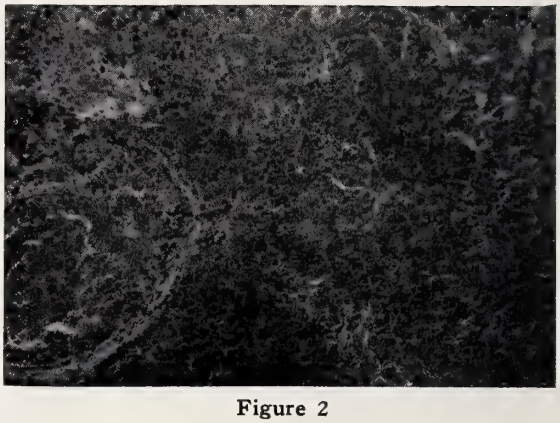


Figure 2

tion with hemorrhage and dissolution of alveolar walls. Heart- Many dilated capillaries. A few scattered round cells and leucocytes between the muscle fibers. Spleen-Congestion; toxic splenitis. Liver-Evidences of shock; necrosis of central zone cells with moderate fatty metamorphosis in this area. Stomach- Small partial erosion through the gastric mucosa, marked congestion of all vessels. Adrenals-Lipoid depletion of cortex; hyperplasia of medulla. Other gross and microscopic findings were within normal limits.

Final Diagnosis:

1. Acute Poliomyelitis.
2. Tracheotomy.
3. Aspirated gastric contents.
4. Massive pulmonary embolism.
5. Infarction of left lung.

6. Pulmonary edema.
7. Aspiration broncho-pneumonia.
8. Toxic Myocarditis.
9. Dillatation of stomach.
10. Acute congestion of all organs.

Autopsy performed by
Dr. H. Ivan Brown.

COMMENT

These cases illustrate the well known difficulty in the clinical diagnosis of pulmonary embolism. In the first case embolism was suspected only after it had happened and in the second case it apparently occurred in the midst of other respiratory symptoms which indicated pneumonia. It is also interesting that in the second case transient petechial spots appeared on the patient's skin eleven days before death. This suggested a bleeding (not clotting) tendency but at that time blood studies were all normal. In neither patient were any drugs administered which normally are considered likely to influence intravenous clotting.

Even though there is a disagreement among medical authorities as to whether or not the incidence of pulmonary embolism is increasing, the fact remains that it is a very common cause of death. Statistical studies show that most cases occur after the age of 40 years and that the predisposing conditions for fatal embolism are; first, cardiac disease, second, surgery; and then a variety of conditions finishing out the list. Clinical cardiac disease rarely occurs in poliomyelitis, but a number of authors have described myocarditis as a cimplication. Among them are Ludden and Edwards (3) and Spain et al. In the reports by these authors the diagnosis was almost always a pathological one, not clinical. In one of Spain's patients the diagnosis was suspected because of a pulse rate of 160. Ludden and Edwards state that the diagnosis is seldom made because of the respiratory difficulties that accompany severe poliomyelitis. Probably in none of these patients was there cardiac decompensation and the circulation was not embarrassed.

This brings up the question of why intravenous clotting of blood occurs. It is certainly not within the scope of this paper to discuss either the intricacies of in vitro clotting or in vivo thrombus formation. Gage (5) believes that one of the many factors is a retarded circulation, which may result in a sludging of the blood, progressing to phlebothrombosis. Since fatal embolism is so rare in poliomyelitis, it must be that clotting factors are not operative in spite of the fact that apparently predisposing and respiratory abnormalities may be present.

SUMMARY

1. Apparently pulmonary embolism is extremely rare as a complication of poliomyelitis.

2. Two cases of this complication, occurring within one week in the same hospital, are reported.

3. Embolism is rare, in spite of the presence in bulbar poliomyelitis of factors which should predispose to embolic phenomena. The conclusion is reached that this is probably because the blood flow is not slowed in bulbar poliomyelitis and therefore intravenous clotting does not occur.

614 S. Seventh St.

REFERENCES

1. Minnesota Poliomyelitis Research Commission 1946; The Bulbar form of Poliomyelitis, J.A.M.A. **134**:757, June 28, 1947.
2. Fowler, Malcolm: A Histopathological Study of Eleven Cases of Poliomyelitis, Including one in the Newborn. The Medical Journal of Australia. **2**:613, Nov. 10, 1951.
3. Ludden, T. E., Edwards, J. E.: Carditis in Poliomyelitis, Am. J. Path. **25**:357, 1949.
4. Spain, D. M., Bradess, V. A., Parsonnett, V.: Myocarditis in Poliomyelitis, Am. Heart Journal **40**:336, Sept. 1950.
5. Gage, Mims: Hidden Thrombus of Fatal Pulmonary Embolism. J.A.M.A. **151**:433, Feb. 7, 1953.

Guillain-Barré Syndrome Simulating a Herniated Intervertebral Disk

Louis D. Boshes, M.D., and Philip Lewin, M.D., Chicago

IT is generally accepted that the Guillain-Barré syndrome can resemble such neurological entities as anterior poliomyelitis, infectious polyneuritis, ascending paralysis and various myelitides. It seems like a far cry in differential diagnosis, however, for a Guillain-Barré syndrome to simulate an intervertebral disk herniation. E. C., who was a patient of P. L. 12 years ago, had at that time a low back derangement that responded completely to conservative measures that included a low back cage brace; physical therapy; and modification of shoes.

When he returned in 1953 with the chief complaint of tired, painful legs and low back pain similar to his presenting picture of 1941 he was told: "Ed, I don't know what is wrong but I want you in the hospital for a neurological survey."

He agreed, and when examined by L.D.B. his condition was diagnosed as a possible Guillain-Barré syndrome.

The patient was a 31 year old, white, male. He was a grain broker. He was admitted to Michael Reese Hospital on December 22nd, 1953 with objective complaints of "sore back" of one week's duration, and a "bad throat" of two weeks' duration. His disk disorder of 1942 followed a fall into a grain elevator. He landed on his buttocks. His right leg flew up and his left leg took the entire body strain. Objective examination at that time revealed a positive Lasègue test at thirty degrees bilaterally, but no sensory disturbance. A spinal fluid examination was uninformative. The x-ray findings were not conclusive. He was treated conservatively and made good progress. He concluded a three year tour of active duty in the Army without eventful episode.

When seen by the neurologist on December 23rd, 1953, the patient complained of pain in the lower back and weakness of both extremities. He told the examiner that he felt precisely as he did when his back was first injured 12 years ago. The right fundus revealed an old chronic choreoretinitis with degenerative changes at the macula. His face was fixed with suggestion of bilateral Cranial VII involvement. A bilateral Lasègue sign was still present. There was definite weakness of both hand-grasps and a suggestive ulnar nerve hypesthesia bilaterally, to pin prick, cotton, and temperature. Deep tendon reflexes were weak. It was felt that there was a generalized involvement of the central and peripheral nervous systems and a tentative diagnosis of the Guillain-Barré syndrome was made. Accordingly, a complete study was made. Only the positive findings will be noted.

A central healed choreoretinitis of unknown etiology was present. A toxoplasmosis complement fixation test was 4+ on 2 occasions but this was not considered specifically contributive for the diagnosis entertained.

Spinal Puncture: (Made on December 26, 1953)

WBC	1
Pandy	trace
Fluid	clear and colorless
Manometrics	normal
Protein	116 mgs per cent
Glucose	66 mgs per cent
Chlorides	711 mgs per cent
Spinal fluid	Negative cultures

Subjectively and objectively the patient did not show much change during the following several days. Accordingly, another spinal puncture was made on January 8th, 1954 at which time there was a 4+ Pandy, 260 mgs of protein with only 4 leucocytes.

At this time it was noted that the patient's voice was becoming more hoarse and weaker. His face became fixed with a suggestion of bilateral cranial VII involvement. An electro-

From the Division of Neuropsychiatry and the Department of Orthopedics, Michael Reese Hospital; and the Departments of Neurology and Psychiatry and Bone and Joint Surgery, Northwestern University Medical School.

lite profile was made. He was then placed on ACTH and 25 units in a 1000 cc. 5 per cent glucose was started intravenously over a period of eight hours, 20 to 30 drops a minute. The indication for ACTH lay in the fact that the patient was beginning to show definite respiratory difficulties and looked and acted like a patient with acute anterior poliomyelitis. In fact, there was a respirator in readiness around the clock. Intravenous ACTH was continued daily for ten days. On the 16th of January a spinal puncture was repeated and three spinal fluid proteins were checked. Spinal level protein was 77 mgs per cent, cisternal 97 mgs per cent, and ventricular 104 mgs per cent. ACTH was dropped to 40 mgs intramuscular doses after a repeat electrolite profile was made. Viral studies for the routine encephalitides were negative. Parphobilinogen studies as well as additional spinal fluid cultures were negative. The usual test for myasthenia grairs was negative.

On the 23rd of January spinal puncture was repeated and the three levels protein quantities were now spinal, 136 mgs per cent, cisternal, 104 mgs per cent, and ventricular, 90 mgs per cent. The ACTH was then increased to 80 mgs daily intramuscularly. On the 29th of January the spinal protein had dropped to 67 mgs per cent. On the 3rd of February it was 58 mgs per cent. The patient was discharged a few days later. The presenting symptoms seen upon admission were no longer present and the patient was subjectively and objectively better. He was advised to report in two weeks.

A spinal puncture was made on February 19th, 1954 revealing the following:

Fluid	Clear and colorless
Manometrics	Normal
WBC	2
Protein	60 mgs per cent

A neurological revealed no subjective or objective deficits in either the central or peripheral nervous systems.

Spinal fluid evaluation tests made in March and in April of 1954 were normal. The patient has remained well and is performing his regular duties.

SUMMARY

We present a case of Guillain-Barre syndrome that appeared to be a disk derangement. It responded to ACTH. The chief index was the protein level of the spinal fluid coupled with the subjective and objective clinical findings.

55 E. Washington St.

‹ ‹ ‹ › › ›

Coronary thrombosis in youth

A study of 34 cases of myocardial infarction observed at the Maxwell Air Force Base Hospital during a four-year period disclosed a definite racial factor. Not a single coronary occlusion occurred in a Negro patient. While the present series is rather small, it suggests that not only age, race, familial history, and obesity are important in the pathogenesis of coronary occlusion, but also that the excessive use of tobacco and alcohol, as well as unusual strenuous activity, may be of significance. It would appear that the diagnosis of myocardial infarction in young persons may quite often be overlooked for several reasons: (1) it is generally regarded as being quite uncommon, and so is not considered; (2) the clinical picture may be definitely atypical. (3) Physical findings relative to the cardiovascular system may be very minimal. Serial electrocardiograms, sedimentation rates and white blood cell counts are frequently required to establish the diagnosis definitely. *Leon V. McVay Jr., M.D. Myocardial Infarction in Younger Age Groups. J.M.A. Alabama July* 1955.

Pathology Conferences

Edwin F. Hirsch, Department Editor

1. Thrombosis of the basilar artery

2. Aneurysmal hemangiectasis (hemangioma) of the cerebrum

Edwin F. Hirsch, M.D., St. Luke's Hospital, Chicago

Case 1. Thrombosis of the basilar artery.

A white male aged 65 years entered St. Luke's Hospital in the care of Doctors Thomas J. Coogan and Joseph Davis on March 8, 1953 and died on April 30, 1953. He was a retired meat inspector and during a routine physical examination in the spring of 1949 was told that he had an unusually high blood pressure. He entered another hospital for further examination at that time and the results of the tests ranged within normal limits. He was given potassium thiocyanate for six months but this was discontinued because of an acute episode of syncope preceded by epigastric pain and tarry stools. Hemorrhage from a peptic ulcer was diagnosed and in another hospital several blood transfusions were given. He remained in good health until March, 1951 when he entered St. Luke's Hospital for further examinations and then was discharged with the diagnosis of "chronic peptic ulcer of the duodenum and nephrosclerosis." On March 23, 1952 the patient was found on the floor by his wife, was brought to the hospital, and found to have a right hemiparesis. His blood pressure was 230/140 mm. Hg. The patient improved slowly, received physiotherapy and thiocyanates, and movements of his right extremities improved considerably. When discharged from the hospital on June 30, 1952 his blood pressure was 140/110 mms. Hg., and the non-protein nitrogen of the blood was 44 mgms percent.

Three days before his final admission to St. Luke's Hospital he had a severe headache, and the day before, his wife observed that mucous secretions collected in his throat and he was restless. Locomotor ability decreased, his left arm and leg weakened, speech and mentally were impaired, and urinary incontinence began.

When admitted on March 8, 1953 his temperature was 100°F. rectally, his pulse 92 and respirations 26 per minute, and the blood pressure was 200/140 mms. Hg. He was unresponsive, his eyes were closed, the right side of his face drooped, much mucus was in his throat, the left extremities had a flaccid paralysis and the left deep tendon reflexes were increased. Both lungs had loud rales. The blood had 5,460,000 erythrocytes and 13,000 leukocytes per c.mm., and 16.1 gms. percent hemoglobin, the non-protein nitrogen of the blood was 30 mgms percent, the fasting blood sugar was 152 mgms. percent, and the carbon dioxide of the plasma was 65 volumes percent. The patient was fed through a stomach tube, pneumonia developed and he died on April 29, 1953.

The essential portions of the anatomic diagnosis of the complete necropsy are:

Obturatory thrombosis of the basilar artery of the brain;

Marked atherosclerosis of the aorta and of its main branches;

Multiple abscesses (2) of the right lung;



Figure 1. Photograph illustrating the thrombosed basilar artery of the brain.

Acute right sero-fibrinous pleuritis;

Marked hyperemia and edema of the lungs;

Marked hypertrophy of the myocardium of the heart;

Nephrosclerosis of the kidneys, etc.

The body weighed 145 pounds and was 169 cms. in length. There was a moderate generalized anasarea, and a slight ascites. The lingula of the upper lobe of the right lung had an abscess 4.5 cms. in diam. Another abscess about the same in size was in the lower portion of the right lower lobe. The pleural surfaces were covered with a fibrinous exudate. Cultures yielded a mixed growth of bacteria. The lungs were markedly edematous and hyperemic. The lining of the aorta had a marked atherosclerosis with scattered superficial atheromas. Each lung weighed 790 gms. The heart weighed 470 gms. and the myocardium of the left ventricle was markedly hypertrophied. The right kidney weighed 170 gms., the left 145. Both had the changes of arteriolar nephrosclerosis. The liver weighed 2100 gms., the spleen 230 gms. They had the changes of chronic passive hyperemia. The posterior wall of the duodenum, just beyond the pylorus had a healed scar 1.5 by 1 cms.

The superficial and deep scalp tissues and the calvarium had no noteworthy changes. The cerebrospinal fluid was clear, the leptomeninges were thin. The cerebral and cerebellar hemispheres were symmetrical. The cerebral arteries at the base of the brain had marked fibrous and fatty changes. The basilar artery, 1.5 cms. (Figure 1) beyond the junction of the vertebral arteries, was filled with a dark red obturator thrombus. The convolutions of the cerebrum were slightly atrophic and the sulci correspondingly widened. The para-central portion of the right cerebral hemisphere especially had atrophic gyri and wide sulci. The brain with the upper half of the dura weighed 1650 gms. The dural and cranial sinuses and both middle ears had no noteworthy changes, so also the structures of the neck.

After fixation in a solution of formaldehyde, further examinations of the brain were made. The obturator thrombus extended 2.3 cms. in the length of the basilar artery and the lumen of the right vertebral artery was markedly narrowed by atherosclerosis of the vessel wall. An old infarct of the left basal ganglia, extending into the cortex, was 5 by 1 by 1 cms. The cerebellum had no changes, but in the ventral portion of the pons was a region of softening 1.2 cms. in max. diam. This was directly opposite the occluded basilar artery.

Sections of the thrombosed portion of the basilar artery had a marked atherosclerotic thickening of the intima and media and the lumen contained a thrombus.

COMMENT

Atherosclerosis of the cerebral arteries complicated by thrombosis of the basilar artery is the basic cause of the clinical symptoms manifested by this patient during a span of several years. The cause of the right hemiparesis with gradual recovery proved to be an old infarct of the basal ganglia and other tissues of the left cerebral hemisphere. Embolic or focal thrombosis is the probable cause of this old infarct. The more recent infarct of the pons is related to the fresh obturator thrombosis of the basilar artery. Atherosclerosis of the cerebral arteries is the basic cause of both vascular lesions of the brain.

Case 2. Aneurysmal hemangiectasis (hemangioma) of the cerebrum.

An adult white female, aged 56 years, entered St. Luke's Hospital in the care of Doctor Chester Coggeshall on September 9, 1953 and died on

September 30, 1953. As a child she was considered to be an epileptic, and at the age of 4 years and again at the age of 8 years her left side was paralyzed. More than 20 years before her present admission a "meningeal cyst" had been removed, and recovery was excellent. More recently she had a neuralgic pain of the left side of her face, and suddenly in the morning of September 8, 1953 she had a severe occipital headache with emesis. She was unconscious when admitted to the hospital. Her temperature was 100°F., pulse 80 and respirations 24 per minute. The right arm and leg were slightly spastic; the left arm and leg were much more spastic. The left arm was held in flexion, the pupils did not react to light. The Babinski, Chaddock and Oppenheim reflexes were positive bilaterally.

The blood had 4,200,000 erythrocytes and 14,900 leukocytes per c.mm., and 12.9 gms. percent hemoglobin. The non-protein nitrogen of the blood was 22 mgms., the sugar 258 mgms. and the CO_2 combining power 57 volumes percent. The urine contained sugar and acetone. The spinal fluid was bloody, xanthochromic and under pressure of 282 mms. of water.

The patient remained unconscious, received supportive treatment and spinal fluid, withdrawn repeatedly, was xanthochromic. Terminally her temperature rose to 108°F.

The essential portions of the anatomic diagnosis of the complete necropsy are:

Congenital aneurysmal hemangiectasis (so-called hemangioma) of the right parietal region of the brain;

Recent spontaneous extensively lacerating right intracerebral hemorrhage of the brain;

Old left intraventricular hemorrhage of the brain;

Blood stained spinal fluid;

Old surgical craniotomy of the right parietal region of the calvarium;

Old surgical defect of the right parietal region of the brain;

Hypostatic hyperemia, edema and bronchopneumonia of the lungs, etc.

The routine gross and microscopic examinations of the tissues of the body (weight 110 pounds) of this adult white female demonstrated no remarkable changes in the neck and trunk structures except hypostatic edema, hyperemia and bronchopneumonia of the lungs. An old healed indistinct surgical scar was in the right temporoparietal region of the scalp, and beneath this was a bone flap 8.5 by 7.5 cms. solidly united with the surrounding bone, with burr holes at the four angles, 1.5 cms. in diam. filled with dense fibrous tissues. The cerebrospinal fluid was bloody. The dural sinuses had no changes.

The right cerebral hemisphere was larger than the left, the convolutions of the cerebrum were moderately flattened and the sulci narrowed. An old defect in the right mid parietal region of the brain was 1.5 cms. in diam. and 1 cm. deep. The brain with the upper half of the dura weighed 1250 gms. The cranial sinuses and both middle and internal ears had no significant changes.

After fixation in a solution of formaldehyde a



Figure 2. Photograph illustrating the aneurysmal hemangiectasis (hemangioma) and internal hemorrhage of the right cerebral hemisphere of the brain.

further examination of the brain was completed. The cerebral arteries had moderate fibrous and fatty changes. The cerebrum was cut coronally at intervals of 1.5 cms. The cortex at the level of the optic chiasma ranged to 3 mms. in thickness. Beneath the small defect mentioned in the right parietal region was a plexiform mass of tortuous and dilated blood vessels with thick fibrous walls, 1 to 5 mms. diam. and larger, occupying a region about 4 cms. max. diam. This extended from the cortex to the right lateral ventricle of the brain. (Figure 2) The dilated right lateral ventricle was filled with blood, the left lateral ventricle was compressed and it contained an older blood clot. The other portions of the brain, the pons, the brain stem, and the upper portion of the spinal cord had no noteworthy changes. Histological preparations of the vascular tissues in the right parietal region of the brain had a fibrillar stroma with many blood vessels ranging in size and with dilated lumens. The wall of the larger vessels was thickened focally by fibrous tissues and in several there were large calcified plaques.

COMMENT

Hemangiectases of the brain as described in the brain of this patient probably is a congenital malformation. Small lesions may have no significance, but the large racemose hemangiectases composed of clusters of veins that involve the full thickness of the cerebrum and extend wedge-like from the pia arachnoid to the lateral ventricle cause serious injury of the brain and death. The manifestation of epileptiform seizures during the childhood of this patient, the later surgical exploration of the right parietal region of the brain with correction of a "brain cyst", and the final episode of spontaneous intracerebral hemorrhage with unconsciousness and death are directly related to the large racemose vascular lesion of the brain. Surgical removal or destruction of such a vascular lesion is hazardous.

‹ ‹ ‹ › › ›

EDITORIALS

Thyroid cancer in childhood

Evidence is increasing that a relationship exists between cancer in children and x-ray therapy for thymic enlargement in infancy. This observation was made originally by Duffy and Fitzgerald.[1] In 10 per cent of their series of 28 children with carcinoma of the thyroid, there was a history of prior irradiation of the thymus gland. Others have reported findings to the contrary.

At a meeting of the Billings Medical Club of Chicago earlier this year, Dwight Clark, of the University of Chicago, reported on the past history of 13 youngsters with carcinoma of the thyroid. All had been irradiated over the neck or upper chest earlier in life because of bronchial disturbances or enlargement of the thymus, tonsils, or cervical lymph glands. In the course of treatment they received from 200 to 750 r of x-rays.

Clark noticed a correlation between the increased incidence of carcinoma of the thyroid and the widespread use of x-ray therapy for thymus conditions. This type of malignancy was rare prior to 1930. But its incidence increased following in the wake of the popularity of x-ray therapy of the thymus. Now that the pendulum has swung in the opposite direction, there is a good possibility that there will be less thyroid carcinoma in children.

Simpson, Hempelmann, and Fuller[2] recently reported data on 1,400 children who had received x-ray therapy in infancy for enlarged thymus, with 1,795 untreated siblings serving as controls. There were 17 malignant neoplasia (including acute leukemia and thyroid carcinoma) in the treated group and five in the untreated. In addition, nine untreated children were found to have thyroid adenoma. The authors stress the importance of dosage as all but three of the malignant neoplasia developed in the group that had received more than 200 r.

These studies may not establish a relationship between malignancy in children and previous x-ray therapy but there is little doubt that the number of cancer cases following thymic irradiation has risen. The time has come to evaluate the long term effects of this type of radiation, especially during infancy.

1. Duffy, B. J., Jr. and Fitzgerald, P. J. Cancer 3:1018 (Nov.) 1950.
2. Simpson, D. M., Hempelmann, L. H., and Fuller, L. M. Radiology 64:840 (June) 1955.

Importance of small hospitals to the nation

An interesting article on the importance of the small hospitals to the Nation was the subject of an article published in a recent issue of *Hospitals,* the official journal of the American Hospital Association. The author of this article is Ray E. Brown, superintendent of the University of Chicago Hospital Clinics and president-elect of the American Hospital Association.

In stressing the importance of the small hos- 5212 general and short term hospitals listed pitals to the nation, he pointed out that of the in 1954, 3,533 are small hospitals. He stated that the hospital with 100 beds or less is the backbone of our nation's hospital care. Using

figures based on the *Administrators Guide Issue*, part II of August 1955 *Hospitals*, it was pointed out that the annual payroll of small hospitals totals approximately one third billion dollars.

The small hospitals in the United States face many problems in their efforts to fulfill their tremendous responsibility to the communities they serve. These hospitals are small only in terms of bed size, and a never ending stream of new services are added as rapidly as research and modern technology introduces them. Mr. Brown said "Even the smallest hospital today has to be a complete medical unit, and they must maintain most of the many services found in the largest hospitals.

In order to keep up, he stated, small hospitals must purchase equipment that has a capacity far in excess of the daily needs that arise in a hospital of less than 100 beds. "Not only is the equipment costly for them, but personnel to operate it is even costlier", he stated.

Mr. Brown noted that although small hospitals have proportionately smaller volume of work, they cannot get by with a proportionately smaller volume of personnel. The hospitals carry on many dissimilar activities, each of which requires long and intensive training on the part of the personnel involved, so the tasks cannot usually be combined. According to Mr. Brown, another high cost and a service expected of the hospital is the "standby feature; an empty bed must be staffed and held ready to serve".

Those of us who have worked in these smaller hospitals, and have had to face the many problems referred to by Mr. Brown, can thoroughly appreciate his fine article. We have seen many hospital training schools closed after years of sucessful operation. Many competent nurses have been graduated from these smaller schools, quite a number of whom have been working in large hospitals and in clinical groups such as the one which Mr. Brown supervises.

Each year it is becoming more difficult for our smaller hospitals to procure enough nurses to properly carry on their work, and this fact is not necessarily confined to small hospitals in rural areas alone. Efforts are being made by the American Medical Association, The American Hospital Association, and by our State Medical Societies to improve the nursing situation, and many still believe that one important factor to relieve this shortage of nurses in smaller hospitals is the reestablishment of training schools in many of them.

‹ ›

The nation's physician population

Some interesting information was released recently by the American Medical Association Council on Medical Education and Hospitals relative to the nation's physician population. The number of new physicians added during 1954 was a record high, as a total of 15,029 licenses were issued. This was an increase of 595 over the previous year. With duplications of candidates examined in more than one state, the actual number of newly licensed physicians was 7,917.

During the year of 1954, 3,667 physicians died, so actually the number added to the physician population was 4,250. A total of 222,773 licenses to practice medicine have been granted since 1945.

It is interesting to note that only 4.2% of the 5,999 American Medical School graduates taking the various examinations failed; 4.8% of the 129 Canadian school graduates failed to pass. The greatest percentage of failures were graduates of foreign schools, as 12.7% of these graduates failed to pass their examinations for licensure.

The largest number of licenses issued to graduates of one school was 207, to those from the University of Illinois College of Medicine. Twenty-six schools had more than 100 licensees. Licenses were issued to graduates of 73 United States medical schools and 11 from Canadian schools. Foreign school graduates including both American and foreign-born persons, took 1,642 examinations with 943 of the candidates passing. New foreign school graduates licensed during the past five years totalled 2,748. In Illinois 435 foreign school graduates took the examination and 216 passed. New York was second with 413 examinations and 184 successful candidates. Ohio and California were third and fourth in the number of foreign school graduates taking licensure examinations.

From this report it is quite obvious that there is an increasing number of physicians being licensed, and the increase is greater than the general increase in the population of the nation.

A smaller number of recent graduates is en-

tering the specialties than was the case a decade or two ago, yet it is still the intention of many newly licensed physicians to start their practice in urban areas. In Illinois, with increasing efforts on the part of rural groups, a gradually increasing number of new physicians are locating in small towns. The Joint Loan Fund of the Illinois State Medical Society and the Illinois Agricultural Association has been an additional incentive to get more physicians into rural areas during the past seven or eight years.

The Physician Placement Service, now in its 12th year, has aided materially in increasing the rural physician population in Illinois. More communities each year are preparing offices, homes, and perhaps a fund to be used to aid new physicians getting established. This Placement Service is operated from the office of the Secretary of the Illinois State Medical Society, and there are few days that letters are not received from physicians seeking a location, and/or from communities wanting a physician.

A report of the activities of the Physician Placement Service was given in the report of the Secretary to the House of Delegates at the 1955 annual meeting of this Society. The report was published in the July issue of the Illinois Medical Journal. It is hoped that all members of the State Society will read this portion of the annual reports, and become more familiar with the work being done to aid rural communities to get a physician.

‹ ›

New ruling tells what are and what are not deductible medical expenses*

The Code broadly defines "medical expenses" as amounts paid (1) for diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body, or (2) for transportation[1] for such purposes.

In the normal case, it is easy to say whether a particular expense is within the definition. In a new ruling,[2] the Internal Revenue Service states its position on certain borderline expenditures. The ruling is issued under the 1930 Code, but will apply, except as indicated, under the 1954 Code.

As to transportation and travel expenses, the ruling made the following points:

1. Necessary taxi fares to and from a doctor's office are deductible.
2. The cost of transportation of a physically handicapped person to and from his place of employment is not deductible. (A District Court case[3] had allowed such cost where the work had a therapeutic value.) Neither is the cost of a small three-wheeled vehicle to "get around."
3. Hotel expenses incurred where daily visits to a medical clinic are required are deductible under the 1939 Code. They would *not* be deductible under the 1954 Code.[1]
4. Where, as the result of an operation for the removal of the larynx, taxpayer is required to go to Florida to relieve breathing difficulties during the winter months, the cost of his trip is a medical expense. Under the 1930 Code, board and lodging would be included; under the 1954 Code, the deductible cost is limited to the transportation expense.[1]

Other points made by the ruling are these:

The cost of special training necessitated by a physical or emotional defect may be deductible. For example, the cost of training a deaf child in speech and lip reading is a medical expense. The same is true as to the cost of psychiatric therapy at a specially equipped school for an emotionally disturbed child. But, the cost of psychotherapeutic treatment in connection with a course in remedial reading will be deductible only if the taxpayer can establish that the treatment is necessary to alleviate a physical or mental defect. In none of these cases is the cost of regular instruction or tuition deductible.

Payments to a health institute where taxpayer takes exercises, rub downs, etc., are deductible only if prescribed by a physician, and he certifies their medical necessity.

Where an insurance policy provides for indemnities of specified amounts for enumerated injuries and also for reimbursement of necessary medical expenses, the premium must be apportioned: the part attributable to the indemnities is not deductible; the part reimbursing for medical expense is.

The cost of an air conditioning device (less salvage value) plus its operating expenses, is de-

*Estate and Tax News, July 1955; prepared by Prentice Hall, Inc.

ductible provided the medical necessity for it is shown and the device is not a permanent part of the dwelling. But the cost of constructing a special room adapted to the operation of an iron lung is not deductible. However, the expenses incurred in operating the iron lung are deductible. (The Court of Appeals for the Third Circuit has allowed a deduction for a mechanical stair inclinator needed by a person suffering from heart disease.[4])

The cost of special mattresses and plywood boards used to relieve an arthritic condition is a medical expense.

The cost of special foods and beverages (e.g., whiskey prescribed by a physician for the relief of angina pains) are medical expenses. But special foods and beverages taken as a substitute for, but not in addition to, normal foods and beverages are not deductible. The cost of oxygen equipment and oxygen is deductible. Note: Under the 1954 Code, the cost of drugs and medicines up to 1% of adjusted gross income is not allowed. It is uncertain whether such limitations applies to these expenses.

The cost of maternity clothing is not a medical expense.

---

[1]The specific inclusion of transportation expenses rules out board and lodging while away (unless incurred as part of a hospital bill) which was allowable under the 1939 Code.

[2]Rev. Rul. 55-261, IRB 1955-18.

[3]Misfeldt, USDC, Minn, 7/31/52.

[4]Hollander, CA-(3), 2/14/55.

The history of medical practice in Illinois

Volume II of The History Of Medical Practice in Illinois came off the press a few days before the 1955 Annual Meeting was held in Chicago. The Secretary's office has sent books to all of those who had signed the pre-publication order blank, and efforts are now being intensified to sell many more copies of this fine book. The Illinois Medical Journal has published editorial comments, and stories pertaining to the contents of this book.

The State Society Committee on Medical History worked for more than seven years to get the material contained in the book, and many hundreds of pages of important medical activities and the work of many pioneer physicians in Illinois are now in the archives currently housed in the John Crerar Library, 86 East Randolph Street, Chicago. The task of preparing future volumes of the medical history of Illinois will be easier than has been the case in the preparation of this volume which covers the period between 1850 and 1900.

The State Society Council asked that a member of each component county society be selected to promote the sale of the book within the respective counties of Illinois. To date, only three Councilor Districts have been organized, and it was recommended that the individual Councilors should aid materially in procuring the names of the county society members selected for this purpose. It is hoped that every county in Illinois will have an official historian designated who will aid in very way possible to get this medical history in the hands of physicians throughout the state, and perhaps too, libraries, hospitals and in many schools.

Physicians desiring a copy of the book may procure one promptly by writing the Secretary, Illinois State Medical Society, P.O. Drawer 156 Monmouth, Illinois. The price of the book is $10.00, the Society paying the postal costs of delivery.

CORRESPONDENCE



New changes and procedures in the doctor draft

Certain physicians liable for service under the so-called Doctor Draft will be physically reexamined if they have not had a physical examination since August 1, 1954. The reason for the examination is to avoid delays in commissioning physicians in the Armed Forces because of questions of physical acceptability and security clearance. The length of time required for security clearance has often delayed the commissioning of physicians. Since August 1, 1954 physicians ordered for physical examination have filled out certain forms at the examining station which expedite their security clearance for commissioning.

Those to be reexamined include the following:

(a) Priority I and II physicians classified in Class 1-A examined and acceptable except those special registrants who will reach their 46th birthday during the calendar year 1955.

(b) Priority III physicians classified in Class 1-A examined and acceptable who were born on or after January 1, 1917.

Physicians not examined since August 1, 1954 will be ordered for reexamination in the sequence in which they will be considered for induction. Local boards will order physicians for physical examination in accordance with instructions issued by the State Selective Service Headquarters. Physicians are urged to arrange to take these physicals when ordered, to avoid delay and confusion.

The authority providing for the induction of persons in medical fields was extended to July 1, 1957 by Congress. However, Section 4 (i) (1) of the Act was amended to provide that no person in the medical field shall be inducted (A) after he has attained the 35th anniversary of the date of his birth, if he applies or has applied for a commission in the medical corps of one of the Armed Forces and is or has been rejected by the Armed Forces for such commission on the sole ground of a physical disqualification, or (B) after he has attained the 46th anniversary of the date of his birth.

This means that a physician 35 years or older whose application for a commission has ever been rejected by the Armed Forces for physical reasons cannot now be called involuntarily to military service. It also means that a physician aged 35 or over, whether he now holds a reserve commission or is a civilian, cannot be involuntarily called to active duty or inducted if, at any time, his application for a commission as a physician has been or is rejected solely on the grounds of a physical disqualification.

Persons who were merely classified in class IV-F by their local boards would not be affected by this new amendment to the law. To be affected a physician must have applied for a commission as a medical officer and must have been rejected on physical grounds.

Col. Paul G. Armstrong
Illinois State Director of Selective Service

‹ ›

Twenty clinics for crippled children listed for October

Twenty clinics for Illinois' physically handicapped children have been scheduled for October by the University of Illinois Division of Services for Crippled Children. The Division will count 14 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination

along with medical social and nursing service. There will be 5 special clinics for children with rheumatic fever and 1 for cerebral palsied children.

Clinics are held by the Division in cooperation with local medical and health organizations, both public and private. Clinicians are selected among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or may want to receive consultative services.

The October clinics are:

October 5 — Hinsdale, Hinsdale Sanitarium
October 6 — Flora, Clay County Memorial Hospital
October 11 — Peoria, Children's Hospital
October 11 — E. St. Louis, Christian Welfare Hospital
October 12 — Alton (Rheumatic Fever), Alton Memorial Hospital
October 13 — Springfield, St. John's Hospital
October 13 — Cairo, Public Health Building
October 13 — Elmhurst (Rheumatic Fever), Memorial Hospital of DuPage County
October 14 — Chicago Heights (Rheumatic Fever), St. James Hospital
October 18 — Quincy, Blessing Hospital
October 18 — Danville, Lake View Hospital
October 19 — Chicago Heights, St. James Hospital
October 20 — Rockford, St. Anthony's Hospital
October 25 — Peoria, Children's Hospital
October 25 — Effingham (Rheumatic Fever), St. Anthony's Hospital
October 26 — Springfield (Cerebral Palsy), Memorial Hospital
October 26 — Elgin, Sherman Hospital
October 27 — Bloomington A.M. (General), P. M. (Cerebral Palsy), St. Joseph's Hospital
October 27 — Mt. Vernon, Masonic Temple
October 28 — Chicago Heights (Rheumatic Fever), St. James Hospital

In carrying on its program the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School and civic and fraternal clubs, visiting nurse associations, local social and welfare agencies, local chapters of the National Foundation for Infantile Paralysis and other interested groups.

In all cases, the work of the Division is intended to extend and supplement — not supplant — activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical and corrective and other services and facilities for diagnosis, hospitalization, and after-care for children who are crippled or who are suffering from conditions which may lead to crippling.

‹ ›

The Academy of Psychosomatic Medicine

The Academy of Psychosomatic Medicine will hold its Second Annual Meeting on October 6th, 7th, and 8th, 1955 at the Plaza Hotel in New York City. The subject of this year's Scientific Program is "The Psychosomatic Aspects of Drug Administration." There is no registration fee. Guests may attend the Banquet.

Speakers include, among others, the following: Lester L. Coleman, M. D., who will talk on "Wonder Drugs—A Psychosocial Phenomenon"; Harry Kozol, M.D., discussing "Epilepsy: Modern Treatment with Drugs as a Keystone of Psychosomatic Method"; George B. Koelle, M. D., presenting "The Clinical Neuro-pharmacology of Mescaline and D-lysergic Acid"; Joseph E. F. Riseman, M.D., commenting on "Experiences with Placebos in the Treatment of Angina Pectoris"; Mark D. Altschule, M.D., presenting "Ideas About the Metabolism of Epinephrine"; and M. Murray Peshkin, M.D., discussing the "Psychosomatic Aspects of Drugs in Allergy Practice."

A preliminary program can be obtained from the Secretary, Ethan Allan Brown, M.D., 75 Bay State Road, Boston, Massachusetts. Reservations should be made directly with the Hotel, and a carbon copy sent to the Secretary's office.

‹ ›

Military surgeons to discuss medical aspects of atomic warfare

The Association of Military Surgeons of the United States will present a comprehensive three-day program on the medical problems facing the military services and the nation in an atomic war. This announcement was made today by the Association President, Major General Joseph

I. Martin, Chief Surgeon of the United States Army in Europe. General Martin said that the entire scientific and professional program of the 62nd Annual Convention of the Association, to be held at the Statler Hotel in Washington, D. C., on November 7th, 8th, and 9th, this year, would be devoted to these problems.

The Convention will be addressed on the first morning by Admiral Lewis L. Strauss, Chairman of the Atomic Energy Commission; by Dr. Frank B. Berry, Assistant Secretary of Defense (Health and Medical); by the Surgeons General of the Army, Navy, Air Force, and Public Health Service; and by the medical chiefs of the Veterans Administration and the Federal Civil Defense Administration. The medical industries of the country also will choose a speaker to address the Convention.

General Martin said that the first afternoon session will discuss the medical effects of nuclear warfare, including the characteristics of nuclear explosions, and the injuiries due to blast, heat, and radiation.

The entire second day's program will be devoted to the Principles of the Care of Mass Casualties. It will cover such important topics as protective measures; initial aid and rescue; sorting of casualties; emergency medical care; cost of delays in treatment; the treatment of large numbers of blast, thermal, radiation, and neuropsychiatric casualties; the use of drugs, blood, and anesthetics in dealing with mass casualties; and the public health, sanitation, and welfare problems in atomic attacks.

The third day will be given over to Organization for the Management of Mass Casualties. The program will discuss the roles to be played by physicians, dentists, veterinarians, nurses, Medical Service Corps officers, Women's Medical Specialist Corps officers, and technical assistants. It will propose ways and means to train these people for their roles in atomic warfare. Finally, the methods for organizing sorting facilities, transportation, fixed and field hospitals, and holding units, to deal with thousands of casualties at one time, will be presented.

General Martin said that each topic will be discussed by an expert in his field who has made a particular study of the medical problems in atomic warfare.

A.M.A. sponsoring three regional medical-legal conferences

The American Medical Association is sponsoring medical-legal conferences this fall in Chicago on October 9 at the American Medical Association Headquarters, in Omaha on October 16 at the Hotel Blackstone and in New York City on October 30 at the Hotel Statler.

The agenda for these conferences have not been completed as yet; however, the programs will be of interest to doctors and lawyers alike. Some of the subjects which will probably be included are: Medical Professional Liability, Trauma and Disease, Medical Science in the Administration of Justice and The Doctor as a Medical Expert Witness.

Although the A.M.A. is anxious to have full participation by both the legal and medical professions, it will be necessary that attendance be limited to 300 persons at each meeting. There will be no registration fee, however, participants will be expected to pay for their own lunch. Members of the Bar who are interested in attending any one of these meetings should register individually by writing to Mr. Joseph Stetler, Director, Law Department, American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois.

« »

Financial aid for student nurses

The Illinois Department of Public Welfare has developed a program for the recruitment of nurses through training grants to students.

The grants under this program will be limited to three years and be open to first, second and third year students in hospital nursing schools or to students enrolled in the last three years of a college or university program in nursing.

Tuition, uniforms, books and fees will be furnished students accepted in the program. In addition, monthly stipends of $30.00 will be paid first year students, $40.00 for those in the second year, and $50.00 for third year students.

Applicants must be citizens of the United States, residents of Illinois, high school graduates, and between the ages of 17 and 35 years. They must be accepted by an Illinois school of nursing approved by the Illinois Department of Registration and Education. The nurse herself

will contact the school of her choice and make arrangements to enroll as a student.

Each student accepted must agree to one year of employment in the Department of Public Welfare for each year he/she receives a grant.

All applicants must be interviewed and recommended by a representative of the Department of Public Welfare.

For further information write to: Miss Florence E. Newell, R.N. Chief, Nursing Service, Illinois Department of Public Welfare, 103 Centennial Building Springfield, Illinois.

Exhibit on uterine cancer test available

The importance of the cytologic test for uterine cancer as a diagnostic aid in routine office practice is explained for physicians in a new exhibit available to medical groups on loan from the National Cancer Institute of the Public Health Service, U. S. Department of Health, Education, and Welfare.

The exhibit was shown for the first time at the American Medical Association meeting at Atlantic City, N. J., in June. It reports the results of the cytologic test as applied to 70,000 women in Memphis and Shelby County, Tennessee, under a project conducted by the National Cancer Institute with the cooperation of local medical and public health groups to demonstrate its value as a case-finding procedure in large populations.

The Memphis project produced a case-finding rate 40 times that previously observed in the community, and 88.3 per cent of the intraepithelial carcinomas of the cervix discovered were unsuspected. Of 1,076 biopsies completed among 70,000 women tested, 544 were positive and 369 negative (the rest being borderline, suspicious, or inadequate).

One of the most important facts revealed by the Memphis data was that intraepithelial carcinoma, or preinvasive "carcinoma-in-situ" in the stage considered practically 100 percent curable, was found most often in women of the 30 to 35 age group. Invasive cancer, on the other hand, was found most often in the 50 to 55 age group.

In addition to presenting these data, the National Cancer Institute exhibit illustrates the aspiration method of taking a vaginal smear for cytologic examination. A folder explaining this procedure in detail, which is helpful in training nurses or medical technologists, is also available from the Institute.

Announcement of the Van Meter Prize Award

The American Goiter Association again offers the Van Meter Prize Award of $300.00 and two honorable mentions for the best essays submitted concerning original work on problems related to the thyroid gland. The award will be made at the annual meeting of the Association which will be held at the Drake Hotel, Chicago, Illinois, May 3, 4 and 5, 1956, providing essays of sufficient merit are presented in competition.

The competing essays may cover either clinical or research investigations, should not exceed 3,000 words in length and must be presented in English. Duplicate typewritten copies, double spaced should be sent to the Secretary, Dr. John C. McClintock, 149½ Washington Avenue, Albany, New York, not later than January 1, 1956. The committee who will review the manuscripts is composed of men well qualified to judge the merits of the competing essays.

A place will be reserved on the program of the annual meeting for the presentation of the winning essay by the author if it is possible for him to attend. The essay will be published in the annual proceedings of the Association.

American Dermatological Association annual prize essay contest

The American Dermatological Association is again offering a series of prizes for the best essays submitted for original work, not previously published, relative to some fundamental aspect of dermatology or syphilology. The purpose of this contest is to stimulate investigators to original work in these fields. Cash prizes will be awarded as follows: Five hundred dollars, four hundred dollars, three hundred dollars and two hundred dollars for first, second, third and fourth place, respectively.

Manuscripts typed in English with double spacing and ample margins as for publication, together with illustrations, charts and tablets, all of which must be in triplicate, are to be submitted *not later than November* 15, 1955.

The manuscripts should be sent to *Dr. J. Lamar Callaway, Secretary, American Dermatological Association, Duke Hospital, Durham, North Carolina.* Those which are incomplete in any of the above respects will not be considered. Manuscripts should be limited to ten thousand words or less and the time of presentation of prize essay shall not exceed thirty minutes. In order to aid fair judgment, papers should be submitted under a nom de plume with no information anywhere in the paper as to the institution or clinic where the work was done. Along with the paper by "John Smith" for example, a plain sealed envelope bearing the nom de plume plus the full name and address of the author is also submitted. Only after all of the papers have been judged and returned to the Chairman are the sealed envelopes opened and the winners known.

Competition in this prize contest is open to scientists generally, not necessary to physicians.

The award will be made by a committee of judges selected to pass on the essays by the Research Aid Committee of the American Dermatological Association and the decision of the judges shall be final. The essays are judged on the following considerations: (1) originality of ideas; (2) potential importance of the work, (3) experimental methods and use of controls; (4) evaluation of results; (5) clarity of presentation. This contest is planned as an annual one, but if in any year, at the discretion of the Committee and judges, no paper worthy of a prize is offered, the award may be omitted.

The results will be announced prior to January 1, 1956, and papers not winning a prize become the authors' property and will be returned promptly. Any paper which wins a prize becomes the property of the American Dermatological Association.

The candidate winning first prize may be invited to present his paper before the annual meeting of the American Dermatological Association with expenses paid in addition to the five hundred dollar prize. Further information regarding this essay may be obtained by writing to the Secretary of the American Dermatological Association.

Midwest Conference On Rheumatic Diseases

The Midwest Conference on Rheumatic Diseases will be held in Detroit, Michigan, Wednesday October 5, at the Henry Ford Hospital. The meeting will be a whole day of postgraduate sessions and will cover practically the entire field of arthritic diseases. The program is sponsored by the Michigan Chapter of the Arthritis and Rheumatism Foundation and the Michigan Rheumatic Society.

Co-sponsorship of this meeting has been obtained from the Department of Postgraduate Medicine, University of Michigan, Medical School, The Michigan State Medical Society, Wayne University College of Medicine, Academy of General Practice and the Wayne County Medical Society. A copy of the program and other information may be procured from James J. Lightbody, M.D., Medical Director, 7338 Woodward Avenue, Detroit 2, Michigan.

‹ ›

Army to pay higher entrance rates to civilian physicians

Authority from the Civil Service Commission has been received to employ civilian physicians at dispensaries, infirmaries, outpatient clinics and laboratories at the top step of each respective grade, according to Major General Silas B. Hays, The Surgeon General.

The new authority, which goes into effect immediately, allows the Army to employ civilian physicians at beginning salaries from $7.465 per annum to $11,395 per annum.

Although increasing numbers of civilian doctors are being employed in Army medical installations throughout the country, openings exist in practically every locality. As of June 30th, according to General Hays, the Army was employing over 20 percent more civilian physicians than it had six months earlier.

Those interested in securing employment with the Army and who have a license to practice medicine in any of the States or the District of Columbia should get in touch with the personnel officer at their nearest Army installation or Army medical facility of their choice.

I.A.G.P. postgraduate program

The Illinois Academy of General Practice seventh annual postgraduate program will open its fall series of six weekly, two hour lectures

Tuesday, October 4 at Chicago Heights and Joliet

Wednesday, October 5 at Alton, Chicago and Hinsdale

Thursday, October 6 at Belleville, Champaign, Danville, Effingham, Geneva, Herrin, Moline, Mt. Carmel, Rockford and Springfield

Friday, October 7 at Elmhurst

Subjects for presentation by the faculties of Chicago Medical School, Stritch School of Medicine, Loyola University and the University of Illinois, Northwestern and University of Chicago Medical Schools, are:

Consultations in Gynecology

Cardiovascular Disease

Common Surgical Conditions

Hematologic Problems in Everyday Practice

Enigmas in Treatment.

‹ ›

Officers of the Chicago Society Of Allergy

At a recent meeting of the Chicago Society of Allergy, the following officers for 1955-56 were elected.

Simon S. Rubin, M.D., President

Helen C. Hayden, M.D., President-Elect

Normal J. Ehrlic, M.D., Secretary-Treasurer

The office of the Secretary-Treasurer, is 111 North Wabash Avenue, Chicago.

‹ ›

Second graduate course in plastic surgery of the head and neck

An intensive course in Plastic Surgery of the Head and Neck will take place at the Morrison Hotel at Clark and Madison Streets in Chicago, Illinois, from October 7th to 9th inclusive, 1955.

The course will be conducted by a faculty of outstanding specialists in this field and will be limited as to the number of participants and to recognized surgeons specializing exclusively in Otolaryngology and Opthalmology and Plastic Surgery of the Head and Neck as set forth in the Directory of the American Medical Association. Louis Joel Feit, M.D., Secretary, 66 Park Avenue, New York 16, N.Y.

‹ ›

New ophthalmology journal

In February 1956 the first issue of *Survey Of Ophthalmology* will appear. It will be a bimonthly, one volume of 600 pages a year, at $9 a volume.

The editor will be Dr. Frank W. Newell, Chief of the Section of Ophthalmology and Associate Professor of Ophthalomolgy at the University of Chicago. He will have the active assistance of a board of about 40 outstanding ophthalmologists. An excellent section on refraction will make the survey of value to progressive optometrists also.

Every aspect of the subject will be covered and critical editorial comments will add to the value of the surveys. Occasional original, lengthy reviews of important subjects in the field of ophthalmology will be a feature.

The Survey will fill a need for a periodical which will select the best material from current periodical literature in ophthalmology to keep the reader up to date with progress in the field.

The Williams & Wilkins Company of Baltimore, Maryland, will be the publishers.

‹ ›

Hospitals to be published twice monthly

Hospitals, the Journal of the American Hospital Association will be published twice monthly beginning January 1, 1956, according to an announcement in its July issue. After several years of study, according to Edwin L. Crosby, M.D., director of the A.H.A., the decision was made by the Association's Board of Trustees. The editorial staff is being expanded to prepare more information and new departments for the magazine. The cover of *Hospitals* will be changed to feature pictures.

On January 1st, the subscription rates for the magazine will be increased from $2.00 to $5.00 per annum, and the publication will come out on the 1st and 16th of each month.

‹ ‹ ‹ › › ›

THE P. R. PAGE



P.R. Page is resumed

The P.R. Page, formerly a popular feature of the Illinois Medical Journal, was discontinued last fall when James C. Leary, Director of Public Relations, had a coronary. His passing last April delayed the resumption. The page now again will be a regular feature, presenting news of interest to those concerned with PR programs.

Fairs Good Medical PR Medium

State and County fairs are excellent — and inexpensive — mediums through which medicine can reach the public. Information on medical progress can be spread at a per capita cost of about 1c. And, this covers only those who are definitely interested.

A good example is the Illinois State Medical Society's exhibit at the annual Illinois State Fair in Springfield. This year's meeting was August 12-21. The Society's exhibit, as in the past, was arranged by Dr. Jacob E. Reisch of Springfield, Councilor for the fifth district. Dr. Reisch had the assistance of the Woman's Auxiliary to the Sangamon County Medical Society.

The 10-day Fair draws a daily attendance of from 50,000 to more than 100,000 people. A daily average of 90,000 or a total of nearly the show, is a conservative figure. This year's gate was nearly 1,000,000.

Supposing only 10 per cent of this attendance displays an interest in the exhibit of the Society, the per capita cost is only about 1c.

According to Dr. Reisch, the major items in as annual expense of $700 are a union movie operator for 10 days, transportation charges of exhibits, labor for setting up and tearing down exhibits, and booth rental. The American Medical Association provides the displays and pamphlets giving health pointers. About 75,000 leaflets are passed out. Auxiliary members staff the booths.

"The medical exhibit started seven years ago as a county auxiliary project," said Dr. Reisch. "It was first housed in a single booth in the grandstand. Public relations medical films were shown in a tent, and leaflets were distributed. Both of these were obtained from the AMA.

"In 1952, the tent was discarded and an open booth maintained. This was repeated in 1953. In 1954, the space was doubled. This larger area, in a favorable location, was used this year. The setup consisted of exhibits, public relations movies and distribution of literature.

"We have found that movies must be 'shorts' —five to seven minutes. Color film is best. Animated, or cartoon, pictures attract the most attention and hold interest. The longer and more serious educational films are not appealing to the transient audience.

"Exhibits with a handle to pull, or a button to push, are the ones most closely inspected. Those with graphs or statistical tables are passed by. If you really want to stop the people, put a scale in the exhibit.

"The types of people attending the Illinois State Fair are variable. The Fair draws a large attendance from farm people. However, other

classes are well represented. We have had school teachers pick up a supply of leaflets for distribution to their pupils.

"It has been noticable that the public each year has shown a greater interest in the medical exhibits. This year's meeting continued that trend.

"The public is realizing more and more that individual responsibility is a big factor in good health."

At this year's Fair, the Illinois State Medical Society again passed out tips on health for farm and city dwellers. A keynote was a 20-foot display exposing some of the quacks of today.

Safe weight reduction methods were shown in exhibits and through motion pictures. "How to Catch a Cold" was the intriguing title of a film which dealt with that common ailment. A third film presented suggestions for the prevention of rheumatic fever. The prevention of accidental poisoning of children was the subject of another exhibit.

PR Program is Recommended

The Illinois State Medical Society's House of Delegates at its recent meeting adopted a committee recommendation "that a more comprehensive statewide public relations program be developed to encourage every county society to formulate a local program suitable to the area needs."

This program, it was pointed out, should include such items as emergency call service, new physician contacts, speaker's bureau, insurance activities and community service.

The adopted report also recommended a closer liaison, through the state society and to the county societies, be set up with the public relations department of the AMA so that all groups will have the full benefit of efforts and material. The report also proposed that this liaison be used to promote the exchange of public relations materials and plans among the component societies of Illinois.

Need for a Psychiatrist?

At the recent annual meeting of the AMA in Atlantic City, an organizational survey committee urged the naming of a committee on labor relations.

The adopted report said:

"We will be meeting and dealing with labor more and more as labor unions increase their activity in the field of fringe benefits, including so-called health insurance. Big labor like big big government is here to stay. Your committee would recommend a psychiatrist on that committee."

NEWS of the STATE



ADAMS

Newspaper Highlights Health Activities.—On Sunday, July 24, 1955, the Quincy Herald-Whig devoted most of its feature section to a review of the health activities in Adams County. Articles reviewed all the work of the county health department, offered tips on health and presented health information of a general nature. Photographs were used to illustrate many of the feature stories.

COOK

Medal Awarded to Warren Furey.—At the annual medical alumni banquet of the Stritch School of Medicine of Loyola University, Dr. Warren Furey, clinical professor of roentgenology at Stritch, was presented with a medal for distinguished service to the Alumni Association. A 1923 graduate of Northwestern University Medical School, Dr. Furey was honored for his work in behalf of his adopted Loyola alumni group. In addition to his position at Stritch, Dr. Furey is radiologist-in-chief at Mercy and Little Company of Mary hospitals, president of the American College of Radiology, past president of the Chicago Roentgen Society, and past president of the Chicago Medical Society.

Dr. Sofield Honored.—Dr. Harold A. Sofield, Oak Park, chief of surgery at the Shriners' Hospital for Crippled Children, was presented with a citation for outstanding work during the recent Shriners' Convention in Chicago.

Grants for Research.—The University of Chicago has received a grant of $50,000 for support of its cancer research program during the current year from the Alexander and Margaret Steward Trust Fund of Washington, D.C., Dr. Lowell T. Coggeshall, dean of the division of biological sciences, announced July 28. The University has received a similar grant for cancer research annually from the Steward Trust Fund for the past five years.—A grant-in-aid for research on tuberculosis was awarded to Dr. Waldemar F. Kirchheimer, associate professor in the department of bacteriology at Northwestern University Medical School, by the National Tuberculosis Association. The grant of $1,800 is for continuing a study of mycobacterial enzyme and growth inhibition.—The Evelyn Steinberg Memorial group recently donated $30,000 to the Mount Sinai Medical Research Foundation. This contribution brings to $80,000 the total given by the group to the foundation since 1951.

Report of Suburban Sanitarium District.—The Suburban Cook County Tuberculosis Sanitarium District, in its recently released 1954 annual report titled the Road to Recovery, presented statistics of an interesting nature. Of the 216,043 residents to receive free 70 millimeter chest x-rays, 10,853 were classified as "suspicious" for tuberculosis or other chest disorders. They were asked to visit the district sanitarium clinics to have a larger chest x-ray and to follow other diagnostic procedures. These services were also made available to people referred by private physicians. Of those seen in the clinics, 62 were found to have tuberculosis; this accounted for more than 19% of the total of 323 new, previously unknown cases of tuberculosis reported in Suburban Cook County in 1954. Clinic services were not limited to x-rays since they provided diagnostic services prior to admission of a patient to a hospital or sanitarium, as well as medical attention following the patient's discharge. The Suburban District Clinic served 1,201 regular outpatients in 1954, offering them 5,852 consultations and 8,730 pneumotherapy or other treatments. Under contractual arrangements with 12 sanitariums, the District provided 510 Suburban Cook County patients with hospital care in 1954, for a total of 75,268 patient days, and at a cost of $660,459.77. Of those hospitalized, 312 were male, 198 were female; 449 were white; and 61 were non-white. The District maintains a twenty bed convalescent home on this site at 55th and County Line Road, Hinsdale, which, in 1954, served thirty-eight patients. The new hospital sanitarium

in Hinsdale admitted its first patients on February 15, 1955. Dr. Edward A. Piszczek is medical director.

Minnesota Psychiatrist Joins University of Chicago.—Dr. C. Knight Aldrich, associate professor of psychiatry at the University of Minnesota Medical School, Minneapolis, has been appointed professor of psychiatry and chairman of the department of psychiatry at the University of Chicago School of Medicine. A native of Chicago and a fifth-generation Chicagoan, Dr. Aldrich received his M.D. degree from Northwestern University in 1940, and served his internship at Cook County Hospital. His chief fields of interest are teaching, both of medical students training to become psychiatrists and of those who will specialize in other branches of medicine, and in furthering integration of psychiatry with other medical specialities. For five years, Dr. Aldrich served as psychiatrist with the U. S. Public Health Service in U.S.P.H.S. hospitals at Lexington, Kentucky, and Fort Worth, Texas. Dr. Aldrich became psychiatrist with the University of Wisconsin Student Health Service in 1946. He joined the faculty of the University of Minnesota Medical School in 1947, where, in addition to his teaching duties, he has acted as liaison psychiatrist with the medical school's department of internal medicine.

Faculty Appointments.—Dr. William F. T. Kellow will become assistant dean of the University of Illinois College of Medicine and assistant professor of medicine, September 1. This is a newly created position approved by the Board of Trustees July 20. Dr. Kellow, who is currently instructor in medicine at Illinois, will divide his time between teaching and assisting Dean Granville A. Bennett in problems of curriculum revision, student scholarship, admissions, student promotions and instruction. Dr. Kellow has also been serving as assistant chief of medicine at the West Side Veterans Administration Hospital since September, 1953.

Dr. David I. Abramson will become head of the department of physical medicine and rehabilitation at the University of Illinois Research and Education Hospitals, September 1. He will succeed Dr. Frances A. Hellebrandt, who will retire from professional life. Before coming to the University of Illinois Department of Medicine in 1946, Dr. Abramson taught at the University of Cincinnati College of Medicine and directed cardiovascular research at the May Institute of Medical Research in Cincinnati.

Research on Multiple Sclerosis.—The University of Chicago Clinics was recently presented with $25,000 by the Multiple Sclerosis Foundation of America for research on the disease. The funds will be used to support research by Dr. Richard Richter, professor of neurology, and Dr. Eugene M. K. Geiling, professor and chairman of the University's Department of Pharmacology. This joint research will be aimed at locating, within the nervous system, certain organic chemical compounds which have previously been injected into the blood stream. For this purpose, drugs and other compounds "tagged" with radioactive chemicals will be used. Some of these drugs are products of the University's "atomic farm" where drug plants are grown in atmospheres containing radioactive carbon dioxide. The compounds will be studied in small laboratory animals. They will include several drugs well known for their damaging effects on nervous tissues.

Changes in the Faculty.—Dr. Bertram Levin, director of the department of diagnostic roentgenology of Michael Reese Hospital has been appointed to the Chicago Medical School faculty as clinical assistant professor of radiology in the department of surgery. Appointed to the Department at the same time were Dr. Harry H. LeVeen, associate professor, and Doctors Helen L. Button and Paul R. Rosenbluth, clinical instructors. Recent appointments to the Department of Medicine are Dr. Lee H. Schlesinger, clinical associate professor; Dr. James B. Berardi, clinical instructor; Dr. Edwin Feldman and Dr. Jerome J. Podgers, clinical assistants; Dr. John F. Polli, research associate in cardiology; and Dr. Arnold Libretti, research fellow in allergy. Other departmental appointments are Dr. Joseph W. Friedlander, associate in psychiatry; Dr. Philip Falk and Dr. Walter Indeck, instructors in orthopedic surgery; and Dr. Minnie Frank, clinical assistant in pediatrics. Two newly-promoted members of the staff are Dr. Lester Wishingrad to instructor in pediatrics and Dr. Louis Richmond to associate in medicine.

Dr. Kagan Goes to California.—Dr. Benjamin M. Kagan, chairman of the department of pediatrics of Michael Reese Hospital, has resigned to accept a similar position at Cedars of Lebanon Hospital, Los Angeles. Dr. Kagan has also been serving as associate professor of pediatrics at Northwestern University Medical School.

Kiwanis Club Donates Gift to Northwestern.—The Rogers Park Kiwanis Club presented a high-fidelity tape recorder to the Northwestern University Cleft Palate and Lip Institute recently. Robert David, president of the club, made the presentation to Dr. Frederick Merrifield, chairman of the institute's executive committee. The Rev. E. S. Ewald, pastor of the Rogers Park Lutheran Church and chairman of the Kiwanis philanthropic committee took part in the ceremonies. The tape recorder is being used in training children to speak well and in research to improve methods of speech development. The institute's research and treatment program was described to the club members by Harold Westlake, Ph.D., director of the speech and hearing clinic at Northwestern's School of Speech, and Dr. John R. Thompson, past director of the Institute.

Personal.—Dr. Herbert Rattner, professor and chairman of the department of dermatology, Northwestern University Medical School, has been appointed editor-in-chief of the Archives of Dermatology, published by the American Medical Association. He had previously served as associate editor for eight years.

New Division of Endocrinology at Presbyterian.—Dr. Theodore B. Schwartz, assistant chief of medicine at the Veteran's Administration Hospital, Durham, N. D., has been appointed chief of the recently established division of endocrinology and metabolic disease in the Department of Medicine at Presbyterian Hospital, effective August 1. With the appointment, Dr. Schwartz received a concurrent appointment as associate professor of medicine at the University of Illinois College of Medicine. Actually, Dr. Schwartz did not assume his new activities at Presbyterian until September 1 to enable him to continue studies at Durham relative to his new position.

The newly organized division of endocrinology and metabolic diseases will conduct investigation under a grant from the John A. Hartford Foundation, Inc., according to Dr. James A. Campbell, Chairman of the department of medicine at Presbyterian.

Dr. Schwartz, who graduated at Johns Hopkins University School of Medicine, has been a member of the faculty of Duke University School of Medicine since 1950, holding his position at the Veteran's Administration Hospital since 1953.

Safety Belts Installed.—The Chicago Fire Department has begun installing safety belts on its cars and fire trucks to curb injuries and deaths among firemen in accidents, the Chicago Tribune reported July 14, 1955. About 1,400 safety belts are to be installed on the department's 275 cars, ambulances, and fire trucks at a cost estimated at $10 each.

KANE

Gift for Research.—Dr. Werner Tuteur, clinical director at Elgin State Hospital, Elgin, Illinois, and clinical associate in neuropsychiatry at Stritch School of Medicine of Loyola University, Chicago, Illinois, was given a grant-in-aid of $3,000 by Smith, Kline, and French Pharmaceutical Company. The grant is to be used to investigate further possibilities of Thorazine® and reserpine on highly disturbed psychotic patients.

WINNEBAGO

Seventy-fifth Anniversary Observed by County Society.—Plans are underway to mark the seventy-fifth anniversary of the Winnebago County Medical Society, October 10-16. Dr. Elmer Hess, President of the American Medical Association, Erie, Pa., will attend the celebration during the first two days of the observance to participate in a television program and address one of the service clubs. On the evening of October 11, Dr. Hess will address the Society at its regular scientific meeting. Members of the Society will appear on radio and television throughout the week and exhibits from the American Medical Association will be on display in the drug stores of Rockford.

On October 11, Mrs. Joseph Lundholm, widow of the late councilor of the first district, will formally present the grandfather's clock which she has donated to the Society as a memorial to Dr. Lundholm. The new headquarters of the Society will also be formally dedicated.

GENERAL

Tuberculosis Hospitals Accredited.—Both State tuberculosis hospitals operated by the Illinois Department of Public Health have now received full accreditation by the Joint Commission on Accreditation of Hospitals, according to the Illinois Health Messenger. The two hospitals are the Chicago State Tuberculosis Sanitarium, which opened in October, 1953 and has a current occupancy of some 260 patients, and Mt. Vernon State Tuberculosis Sanitarium which was dedicated in May, 1951. The latter institution has a capacity of 100 beds and provides care for about 250 patients annually.

Illinois Health Messenger Revived.—The official publication of the Illinois State Department of Public Health, Illinois Health Messenger, made its reappearance in July after suspended publication for two years. The Messenger was abandoned in July 1953 because of economic exigencies. In the face of continued financial stress and with every attempt being made to maintain economic efficiency, the Department will publish the Messenger monthly since it recognizes the need for and the interest in a public health newsletter. The revived issue carries a brief review of the health progress in the past two years. In addition it announced that the Michael Reese Research Foundation and the Illinois Department of Public Health were awarded special commendation by the Illinois State Medical Society at the organization's annual meeting in May for research work on investigation of an ultra violet irradiated poliomyelitis vaccine. The Messenger reported, too, that, despite the ever increasing number of older people in the population, the 1954 death rate was lower by about 5 per cent than that for the previous year. It announced that a total of about 92,500 deaths in the state last year, or a rate of 10.2 per thousand population, compares with a total of 96,607 deaths in 1953 with a rate of 10.7.

Heart disease continued to be the leading cause of mortality in 1954, with an estimated 39,000 deaths, or a rate of 428 per 100,000 population. Indications are that this will be the lowest death rate from heart disease in Illinois since 1948. Gratifying also is the decrease in the number of fatal accidents to an estimated 4,900. The 1954 accidental death rate of 54 per 100,000 population is the lowest recorded in more than a decade. It now appears that all but

three of the leading causes of death were responsible for decreased mortality last year. Those accounting for slightly higher estimates include cancer, which increased from 15,159 fatalities in 1953 to an estimated 15,400 in 1954; congenital malformations and certain diseases peculiar to early infancy from 4,294 to 4,400; and general arteriosclerosis from 1,631 to 1,700.

Rear Admiral Swanson Retires.—Rear Admiral Clifford A. Swanson, ninth naval district, medical officer at Great Lakes, recently retired after thirty years of active naval service, the Chicago Tribune reported July 21. He has been succeeded by Rear Admiral Walter F. James, who served as medical officer of the thirteenth naval district in Seattle.

The Joseph Capps Prize.—The Institute of Medicine of Chicago is offering an annual prize of $300 for the most meritorious investigation in medicine or in the specialties of medicine. The investigation may also be in the fundamental sciences, provided the work has a definite bearing on some medical problem. The prize, named in honor of the late Dr. Joseph Capps, was founded by Dr. and Mrs. Edwin R. LeCount. Competition for 1955 is open to graduates of Chicago medical schools who completed their internship or one year of laboratory work within a period of five years prior to January 1, 1955, excluding their terms of service in the Armed Forces. Manuscripts must be submitted to the Secretary of the Institute of Medicine of Chicago 86 East Randolph Street, Chicago 1, not later than December 13, 1955. The manuscript of the prize paper, as submitted is to become the property of the Institute of Medicine of Chicago. The prize winner may be invited by the Board of Governors of the Institute to present his paper at a meeting of the Institute. If no paper submitted is deemed worthy of the prize, the award may be withheld at the discretion of the Board of Governors.

Illinois Physicians Receive Certificates.—During the annual convocation of the American College of Chest Physicians in Atlantic City, June 4, certificates of fellowship were awarded to 251 members from forty-two states, the District of Columbia, five provinces of Canada, Brazil, Korea, and the Philippines. Illinois physicians who were honored are: Edward E. Avery, Chicago; William E. Barnes, Waukegan; J. Harry Bendes, Rockford; Elmer I. Bernstein, Chicago; Francis R. Prock, Joliet; Herman C. Rogers, Mount Vernon; Laurence H. Rubenstein, Chicago, and Joseph Shanks, Chicago. Dr. George F. Lull, Secretary and General Manager of the American Medical Association, also was given honorary fellowship in the College.

Meeting of Obstetricians and Gynecologists.—The 1955 summer session of the Illinois Obstetrical and Gynecological Society held a dinner meeting in Waukegan, August 3, at the Swedish Glee Club. The following day a clinical session was held at the Abbott Laboratories. Demonstrations of some of the newer medical uses of radioactive isotopes were held by Dr. D. L. Tabern, head of the division of radioactive isotopes pharmaceuticals of Abbott Laboratories. "Uses of Radio Gold in the Treatment of Cancer of the cervix" were presented in a paper and motion picture film by Dr. Willard M. Allen, professor of obstetrics and gynecology, Washington University School of Medicine, St. Louis. Officers of the Illinois Obstetrical and Gynecological Society are Worling R. Young, M.D. Geneseo, president; Carl Greenstein, M.D., Champaign, president-elect; R. E. Bucher, M.D., Danville, vice-president; G. H. Edwards, M.D., Pinckneyville, secretary; H. E. Smith, M.D., Maywood, treasurer; David M. Jenkins, M.D., Bloomington, assistant secretary.

Financing of Mental Care.—Money contributed by families of State Hospital Patients will be used to finance a 16 million dollar, two year program to improve mental health services in Illinois. According to a newspaper report, the funds will provide better care for inmates of mental hospitals, increase support for community clinics, scholarships to train more psychiatrists and other specialists, and new hospital buildings. Almost four million dollars a year is being received for the State's mental health funds by families, when they can afford it, for the care, treatment, detention, and training of hospital inmates. Newspapers report that, on a graduated scale, the payments range from $9 to $60 a month. The average is about $30. But payments are made for only 20 per cent of the inmates, since families of the others are in low income brackets and hence exempt under the 1951 law which created the fund. A total of eight million dollars will go to construction of a psychiatric training hospital at the Chicago Medical center. Bids are expected to be let early next year. Its chief function will be to train men and women needed to fill staff shortages at welfare department institutions.

"Your Doctor Speaks" over WFJL.—The following physicians have recently participated in the series "Your Doctor Speaks" over FM Station WFJL, Thursday evenings, at 7:45 p.m. The series is presented under the auspices of the **Educational Committee** of the **Illinois State Medical Society:**

Harry F. Weisberg, clinical chemist, Mount Sinai Medical Research Foundation and Hospital, July 28, on Role of Laboratory Tests in Clinical Medicine.

Adolph Rostenberg, Jr., professor of dermatology, University of Illinois College of Medicine, August 11, on Allergic Conditions of the Skin and Hot Weather Skin Troubles.

"All About Baby" on WGN-TV, Channel 9.—The following physicians have appeared on the telecast **"All About Baby"** on **WGN-TV, Channel 9,** under the auspices of the **Educational Committee** of the **Illinois State Medical Society.** The telecast,

a Jules Power Production, features Lorraine Douglas, R.N.

Joseph A. Bertucci, clinical instructor in pediatrics at Stritch School of Medicine of Loyola University, August 12, on When Baby Goes Outdoors and Traveling.

Peter J. Cotsirilos, head of the department of pediatrics, Oak Park Hospital, August 17, 1955, on Proper Time of Weaning from the Breast—from the Bottle.

George L. Perkins, consultant in child psychiatry at the Orthogenic School of the University of Chicago, August 24, on Psychiatry and Your Child.

Lectures Arranged Through the Scientific Service Committee of the Illinois State Medical Society:

Albert Walter Wise, Rock Island, McDonough County Medical Society at the LaMoine Hotel, Macomb, September 23, on Present Concepts of Coronary Disease.

Walter J. Reich, Chicago, Kane County Medical Society at the St. Charles Country Club, St. Charles, October 12, on Office Gynecology.

R. Gordon Brown, Chicago, Iroquois County Medical Society at the Christian Church, Watseka, on Treatment of Radiation Injuries (Atomic).

Louis R. Limarzi, Chicago, Stock Yards Branch to the Chicago Medical Society, November 18, on What's New in Blood Treatment.

DEATHS

Victor H. Burkhart*, Hurst, who graduated at the Chicago College of Medicine and Surgery in 1910, died July 27, aged 73. He had practiced medicine in Hurst for 40 years and was former mayor.

Frank Benson Deardorff*, Berwyn, who graduated at the University of Illinois College of Medicine in 1935, died July 12, aged 49. He was head of the department of obstetrics and past president of the staff of MacNeal Memorial Hospital.

Joel L. Deuterman*, Elgin, who graduated at the University of Virginia Department of Medicine in 1930, died August 7, aged 53. He was president of the staff of the Sherman Hospital.

Harry Barham Dickinson*, Coulterville, who graduated at Washington University School of Medicine, St. Louis, in 1927, died in June, aged 58.

August Frederick Doerann*, Evanston, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1910, died June 12, aged 75, of gastrointestinal hemorrhage and gastric ulcer.

Zoltan Glatter*, East Moline, who graduated at Magyar Királyi Pázmány Petrus Tudományegyetem Orvosi Fakultasa, Budapest, in 1923, died June 17, aged 63.

James Barnard Hastings*, Alton, who graduated at Washington University School of Medicine, St. Louis, in 1905, died May 21, aged 72. He was plant physician for the Wood River Refinery of Standard Oil Company, and a member of the staffs of the Alton Memorial and St. Joseph's Hospitals.

James Clayton Henry*, East St. Louis, who graduated at the Chicago College of Medicine and Surgery in 1912, died May 24, aged 76, of arteriosclerotic heart disease and hepatitis. He had served on the staffs of St. Mary's and the Christian Welfare Hospitals.

Raymond M. Kelly*, retired, Chicago, who graduated at Loyola University School of Medicine in 1916, died July 15, aged 64. He was a past president of the Board of St. Anne's Hospital.

Elmer C. Leininger*, Chicago, who graduated at Northwestern University Medical School in 1911, died in his country home in Culver, Indiana, July 11, aged 62.

Jacob J. Mendelsohn*, Chicago, who graduated at the Chicago College of Medicine and Surgery in 1912, died July 26, aged 66. He was professor of medicine at Stritch School of Medicine of Loyola University.

William J. Mitchell*, Chicago, who graduated at Rush Medical College in 1903, died July 28, aged 73. He had practiced medicine in Chicago over 50 years.

George L. Perusse*, Chicago, who graduated at Jenner Medical College in 1908, died July 15, aged 79. He was a member of the staffs of Grant and Columbus Hospitals, and a former superintendent of Michael Reese Hospital.

Abram Martin Puris*, Park Ridge, who graduated at the University of Nebraska College of Medicine in 1919, died July 15, aged 57. He was a member of the staff of the Children's Memorial Hospital.

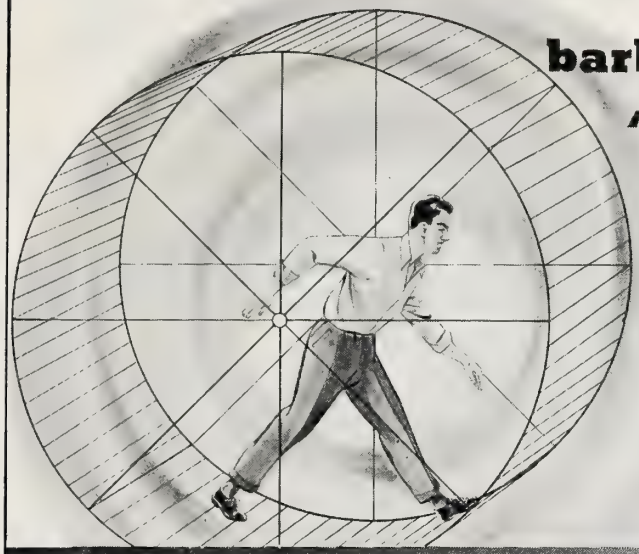
James R. White, retired, Chicago, who graduated at Meharry Medical College, Nashville, in 1897, died July 26, aged 84. He had served as senior staff gynecologist at Provident Hospital until his retirement in 1935.

---

*Indicates member of the Illinois State Medical Society.

a *refreshing* sedative that

***SLOWS TENSION* without barbiturate "phobia" or hangover**



SLOWTEN

[Phenobarbital and Thiamine]

SLOWTEN PATCH

no "phobia" because SLOWTEN is a name your patient will not identify as a barbiturate on prescriptions...

no hangover because of the tone-restoring effect of thiamine in SLOWTEN.

SLOWTEN Tablets
Each tablet provides phenobarbital, ¼ gr. (16.2 mg.) and thiamine hydrochloride, 5 mg.; in bottles of 100.

SLOWTEN Elixir
Each pleasantly flavored teaspoonful (5 cc.) provides phenobarbital, ¼ gr. (16.2 mg.) and thiamine hydrochloride, 5 mg.; in bottles of 1 pt. and 1 gal.

THE E. L. PATCH CO. – STONEHAM, MASSACHUSETTS

BOOK REVIEWS

Christopher's MINOR SURGERY By Ochsner and DeBakey Edited: Alton Ochsner, M. D., F.A.C.S., William Henderson, Professor of Surgery and Chairman of the Department of Surgery, Tulane University of Louisana School of Medicine and Michael E. DeBakey, M. D., F.A.C.S. Professor of Surgery and Chairman of the Department of Surgery, Baylor University College of Medicine. Seventh Edition. Published by W. B. Saunders Company, Philadelphia and London.

Copyright 1955 Price $9.00

The Seventh Edition of this standard textbook has been so completely revised that it almost constitutes a new textbook.

The type, paper, illustrations and general layout have all been radically changed for the better. The material is well organized and adequately indexed.

The authors are so well known that the quality of the text has been virtually insured.

It offers a host of routine problems and solutions commonly considered to comprise minor surgery. This text is eminently practical, concise and readable.

‹ ›

NEUROLOGY, Second Edition, 1955, Three Volumes by S. A. Kinnier Wilson, Edited by A. Ninian Bruce. The Williams and Wilkins Co.

The first edition of this classic work was published in 1940, a number of years after the death of Dr. Wilson. The present new edition fifteen years later is a valiant attempt on the part of Dr. Bruce the editor to include recent advances in the field of neurology. An important omission in the first edition is corrected in the second edition with a chapter on aphasia, apraxia and agnosia, by Sir Russell Brain. This second edition retains the excellent descriptions of the various neurological disorders, but too often modern therapies are not given adequate consideration. An example is the failure to give references to some of the newer antibiotics in the treatment of central nervous system infections. Another defect is the too frequent use of proprietary names familiar to British users but unknown to Americans.

The section on Neuroses continues to be a semantic wilderness and modern concepts of the psychophysiological nature of some of the diseases discussed are not given adequate evaluation and consideration.

Despite these and other defects, the excellence of this neurological work will doubtless win a place for it in the libraries of neurologists, but for others in the varied specialties of medicine its value will probably be somewhat diminished but will nonetheless be of significant worth.

W.H.B.

‹ ›

HANDBOOK OF MEDICAL TREATMENT. Fourth Edition by Milton J. Chatton, A.B., M.D. Director of Medical Institutions, Santa Clara County, California. Sheldon Margen, M.A., M.D., Associate Research Biochemist, Department of Physiological Chemistry and Clinical Instructor in Medicine, University of California School of Medicine, San Francisco. Henry D. Brainerd, A.B., M.D., William Watt Kerr Associate Professor of Clinical Medicine, University of California School of Medicine, San Francisco Visiting Physician, Chief of

(*Continued on page* 68)

MORE BOAT FOR THE MONEY!



30-ft. Flagliner Express



Troll from comfortable swivel chairs. Get mackerel, tarpon, cobia, sailfish!



Ladies love the big, roomy cabin. luxurious equipment and galley.



Air foam mattresses, good, stable design, make for restful sleep.

A Profitable Investment in Good Times Afloat!

When symptoms indicate recreation afloat, here is the boat that fills your prescription with integrity. Thirty feet of sturdy steel Safticraft, made by craftsmen familiar with Gulf water requirements for top performance and safety. Speed up to 23 miles per hour. Comfortably large enough for yourself and your family or friends. Luxuriously appointed. Sleeps four restfully. Because it is built right here in Louisiana, you have the finest service facilities close at hand. We make smaller—and larger—models, but this size has proved to be the outstanding favorite among professional men from coast to coast. This season, invest in life-preserving relaxation and fun afloat. Send in the coupon for further details and prices.

E. W. & A. P. Dupont, Inc., Dept. M
Morgan City, La.

Please send me details on the Safticraft Express Flagliners:

☐ 30' Flagliner Express ☐ 34' Flagliner Express
☐ 36' Flagliner Express

Name_____

Address_____

City_____ State_____

Another Lederle "First"!

MUMPS VACCINE

A practical immunizing antigen for prevention of mumps in children or adults where indicated.
Immunizes for about one year.
Packages: 2 cc. vial (1 immunization),
10 cc. vial (5 immunizations).

LEDERLE LABORATORIES DIVISION
AMERICAN Cyanamid COMPANY
PEARL RIVER, NEW YORK

Lederle

BOOK REVIEWS (Continued)

Medical Service, San Francisco Hospital, San Francisco. Published by Lange Medical Publications. Post Office Box 1215, Los Altos, California.

Copyright 1954 Price $3.00

This is another splendid example of the excellent booklets put out by Lange Medical Publications. It is pocket size although over 500 pages in length. Its compactness is realized by careful condensation until only the basic facts covering a specific disease entity remain. In spite of its brevity very little essential material has been deleted. However, it was noted that in the chapter on vitamins, no consideration was taken of vitamin A poisoning.

There are 22 chapters in this present volume, all cleverly indexed with black markers, on the right border, for rapid identification. At the close of the book is a detailed subject index.

This handbook should occupy a place on the night stand or desk of every physician actively engaged in the practice of medicine.

(*Continued on page* 70)

1950 Cortone® | 1952 Hydrocortone®
1954 'Alflorone' | 1955 'Hydeltra'

DELTRA®

tablets

(Prednisone, Merck)

2.5 mg. - 5 mg. (scored)

the delta$_1$ analogue of cortisone

Indications:
Rheumatoid arthritis
Bronchial asthma
Inflammatory skin conditions

SHARP & DOHME
Philadelphia 1, Pa.
DIVISION OF MERCK & CO., INC.

Upjohn

Gradual and sustained lowering of blood pressure:

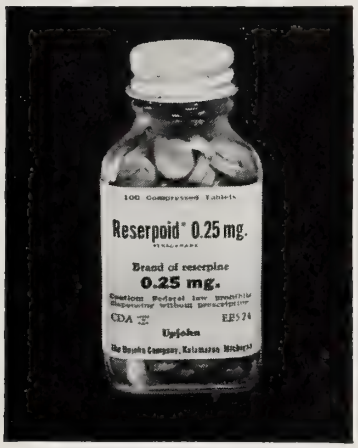
Each tablet contains:

Reserpine . . . . . 0.1 mg.
or 0.25 mg.
or 1.0 mg.

Supplied:

Scored tablets
0.1 and 0.25 mg. in bottles of 100 and 500
1.0 mg. in bottles of 100

The Upjohn Company, Kalamazoo, Michigan



Reserpoid

TRADEMARK FOR THE UPJOHN BRAND OF RESERPINE

(Pure crystalline alkaloid)



DEMISULF
by Yates

The pleasant cinnamon flavor of this children's sulfa tablet carries clear through—no bitter after-taste. Children will accept your therapy gladly because Demisulf can be chewed or will disintegrate rapidly in a teaspoonful of water.

Doctors have found Demisulf most successful for treating their young patients with a well balanced sulfa combination.

Sulfadiazine	*0.083 Gm.*
Sulfamerazine	*0.083 Gm.*
Sulfamethazine	*0.083 Gm.*
(Represents Total Sulfonamides	*0.250 Gm.)*

Try Demisulf for your next young patient. Send for your free testing sample today.

Please send me my testing sample of Demisulf along with complete information.

Name_____

Street_____

City_____ Zone____ State_____

YATES DRUG COMPANY
295-303 Lafayette Street, New York 12, N. Y.

BOOK REVIEWS (Continued)

OBSTETRICS. Eleventh Edition, 1170 Illustrations on 910 Figures, 144 in Color. By J. P. Greenhill, M.D., Senior Attending Obstetrician and Gynecologist, The Michael Reese Hospital; Obstetrician and Gynecologist, Associate Staff, The Chicago Lying-in Hospital; Attending Gynecologist, The Cook County Hospital; Professor of Gynecology, Cook County Graduate School of Medicine. Published by W. B. Saunders Company, Philadelphia, London.

Copyright 1955 Price $14.00

Great changes have occurred in the Eleventh Edition of this standard textbook. Although only four years have passed since the last edition, the changes and improvements are so extensive as to almost constitute a new text. Many of the old illustrations have been removed in this edition and over 125 new illustrations, many in color, have been added.

The section on the management of Rh mothers and fetal erythroblastosis is exceptionally well done incorporating the latest experimental and clinical advances in the management of this difficult obstetrical problem.

It is with nostalgic regret that the deletion of Dr. DeLee's name from the title page is noted in this edition. Perhaps the redundance of the pronoun "I" as the introduction of sentences may give a clew to those sentimental old souls who learned to love and respect this grand old man while they were learning their first lessons in obstetrics.

J.W.P.

BOOKS RECEIVED

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

FRACTURES AND JOINT INJURIES: By Sir Reginald Watson-Jones, F.R.C.S., Extra-Orthopaedic Surgeon to Her Majesty the Queen; Orthopaedic Surgeon to His Late Majesty, King George VI; Director, Orthopaedic and Accident Service, London Hospital, etc., Volume II, Fourth Edition. Williams & Wilkins Company, 1955. Price $22.00 (two volumes).

NEW AND NONOFFICIAL REMEDIES, Containing Descriptions of the Articles which stated accepted by the Council on Pharmacy and Chemistry of the American Medical Association on January 1, 1955. J. B. Lippin-

(*Continued on page 72*)

establishing

desired

eating patterns



Obedrin®

and the 60-10-70 Basic Diet

Correct medication is important in initiating control that leads to development of good eating habits, essential in maintaining normal weight.[1,2,3]

Obedrin contains:

- Methamphetamine for its anorexigenic and mood-lifting effects.
- Pentobarbital as a corrective for any excitation that might occur.
- Vitamins B_1 and B_2 plus niacin for diet supplementation.
- Ascorbic acid to aid in the mobilization of tissue fluids.

Obedrin contains no artificial bulk, so the hazards of impaction are avoided. The 60-10-70 Basic Diet provides for a balanced food intake, with sufficient protein and roughage.

Formula:

Semoxydrine HCl (Methamphetamine HCl) 5 mg.; Pentobarbital 20 mg.; Ascorbic acid 100 mg.; Thiamine HCl 0.5 mg.; Riboflavin 1 mg.; Niacin 5 mg.

1. Eisfelder, H. W.: Am. Pract. & Dig. Treat., 5:778 (Oct.) 1954.

2. Sebrell, W. H., Jr.: J.A.M.A., 152:42 (May) 1953.

3. Sherman, R. J., M.D.: Medical Times, 82:107 (Feb.) 1954.

Write for 60-10-70 Diet pads, Weight Charts, and samples of Obedrin.

THE S. E. MASSENGILL COMPANY

Bristol, Tennessee

BOOKS RECEIVED (Continued)

cott Company, Philadelphia, 1955. Price $3.35.

Virus and Rickettsial Diseases: By S. P. Bedson, M.D., Emeritus Professor of Bacteriology, University of London; F. O. MacCallum, M.D., Director Virus Laboratory, Central Public Health Laboratory; A. W. Downie, M.D., Professor of Bacteriology, University of Liverpool; C. H. Stuart-Harris, M.D., Professor of Medicine, University of Sheffield. Williams & Wilkins Company, Baltimore, 1955. Price $6.75.

Medical Problems of Old Age: By A. N. Exton-Smith, M.D., Physician, Whittington Hospital, London. With a foreword by The Rt. Hon. Lord Amulree, M.D., F.R.C.P. Bristol; John Wright & Sons, Ltd., 1955. The Williams & Wilkins Co., Baltimore. Price $7.00

Clinical Biochemistry: By Abraham Cantarow, M.D., Professor of Biochemistry, Jefferson Medical College; Max Trumper, Ph.D., Formerly Lecturer in Clinical Biochemistry and Basic Science Coordinator, Naval Medical School, National Naval Medical Center, Bethesda, Maryland. Fifth Edition; 738 pages; 54 figures. Publication date June 3, 1955. Price $9.00. W. B. Saunders Company, Philadelphia and London.

Systemic Associations and Treatment of Skin Diseases: By Kurt Wiener, M.D., Dermatologist, Mount Sinai Hospital, Deaconess Hospital, Saint Michael's Hospital, Milwaukee, Wisconsin. With 90 Text Illustrations. The C. V. Mosby Company, St. Louis, 1955. Price $17.00.

Bone and Bones. Fundamentals of Bone Biology: By Joseph P. Weinmann, M.D., College of Dentistry, University of Illinois, Formerly at School of Dentistry, Loyola University, Chicago; and Harry Sicher, M.D., D.Sc., School of Dentistry, Loyola University, Chicago. With 302 Illustrations. Second Edition. The C. V. Mosby Company, St. Louis, 1955. Price $13.75.

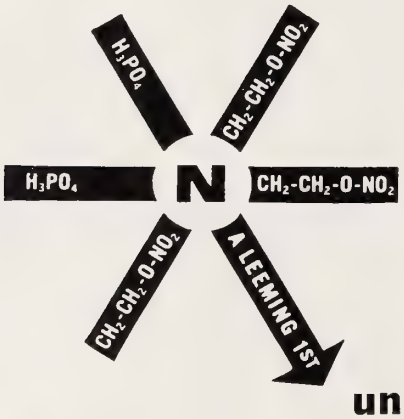
Hypotension: Shock and Cardiocirculatory Failure: By Paul G. Weil, M.D., Ph.D., Director of Transfusion Service, Royal Victoria Hospital, Montreal, Canada. The J. B. Lippincott Company, Philadelphia. Price $2.25.

Everything and the Kitchen Sink. By Farrar, Straus & Cudahy, New York. $4.00.

Communicable Diseases. By Franklin H. Top, A. B., M. D., M. P. H., F. A. C. P., F. A. A. P., F. A. P. H. A., Professor and Head, Department of Hygiene and Preventive Medicine and Director, University Department of Health, State University of Iowa. 109 text illustrations and 15 color plates. Third edition. The C. V. Mosby Company, St. Louis. $18.50.

Modern Drug Encyclopedia and Therapeutic Index. Edited by Marion E. Howard, M.D., F.A.C.P., Associate Clinical Professor, Department of Internal Medicine, Yale University School of Medicine. Sixth edition. Drug Publications, Inc., 49 West 45th Street, N. Y. 36, N. Y. $15.00.

Angina pectoris prevention



Most efficient of the new long-acting nitrates, Metamine prevents angina attacks or greatly reduces their number and severity. Tolerance and methemoglobinemia have not been observed with Metamine, nor have the common nitrate side effects such as headache or gastric irritation. Dose: 1 or 2 tablets after each meal and at bedtime. Also: Metamine (2 mg.) with Butabarbital (¼ gr.), bottles of 50. Thos. Leeming & Co., Inc., 155 East 44th Street, New York 17, N.Y.

unique amino nitrate

Metamine®

triethanolamine trinitrate biphosphate, Leeming, tablets 2 mg. Bottles of 50 and 500



Because the fever of infection increases metabolic needs

Tetracyn® SF*

Brand of tetracycline

is indicated • to combat the invading organism with TETRACYN, the newest and best-tolerated broad-spectrum antibiotic

• to support the patient's natural defenses with the vitamins essential for resistance and recovery

with a single prescription. This concept, originated by Pfizer,

results in • maximum antibiotic blood levels[1]

• superior clinical effectiveness[2]

• superior toleration[3]

Terramycin® † SF* is a similar combination; the average daily dose (1 Gm.) of Tetracyn or Terramycin supplies the needed amount of a special vitamin formula recommended by Pollack and Halpern[4] for nutritional therapy of patients under physiological stress.

Supplied: TETRACYN SF, Capsules 250 mg.; Oral Suspension (fruit flavored) 125 mg./5 cc. teaspoonful.
TERRAMYCIN SF, Capsules 250 mg.

1. Dumas, K. J.; Carlozzi, M., and Wright, W. A.: Antibiotic Med. *1*:296 (May) 1955. 2. Prigot, A.: Ann. New York Acad. Sc., in press. 3. Milberg, M. B., and Michael, M., Jr.: Ibid. 4. Pollack, H., and Halpern, S. L.: Therapeutic Nutrition, Prepared in Collaboration with the Committee on Therapeutic Nutrition, Food and Nutrition Board, National Research Council, Washington, D. C., 1952.

*Trademark for Pfizer brand of antibiotics with vitamins.
†Brand of oxytetracycline

Pfizer PFIZER LABORATORIES, Division, Chas. Pfizer & Co., Inc., Brooklyn 6, N. Y.

Tumor registry

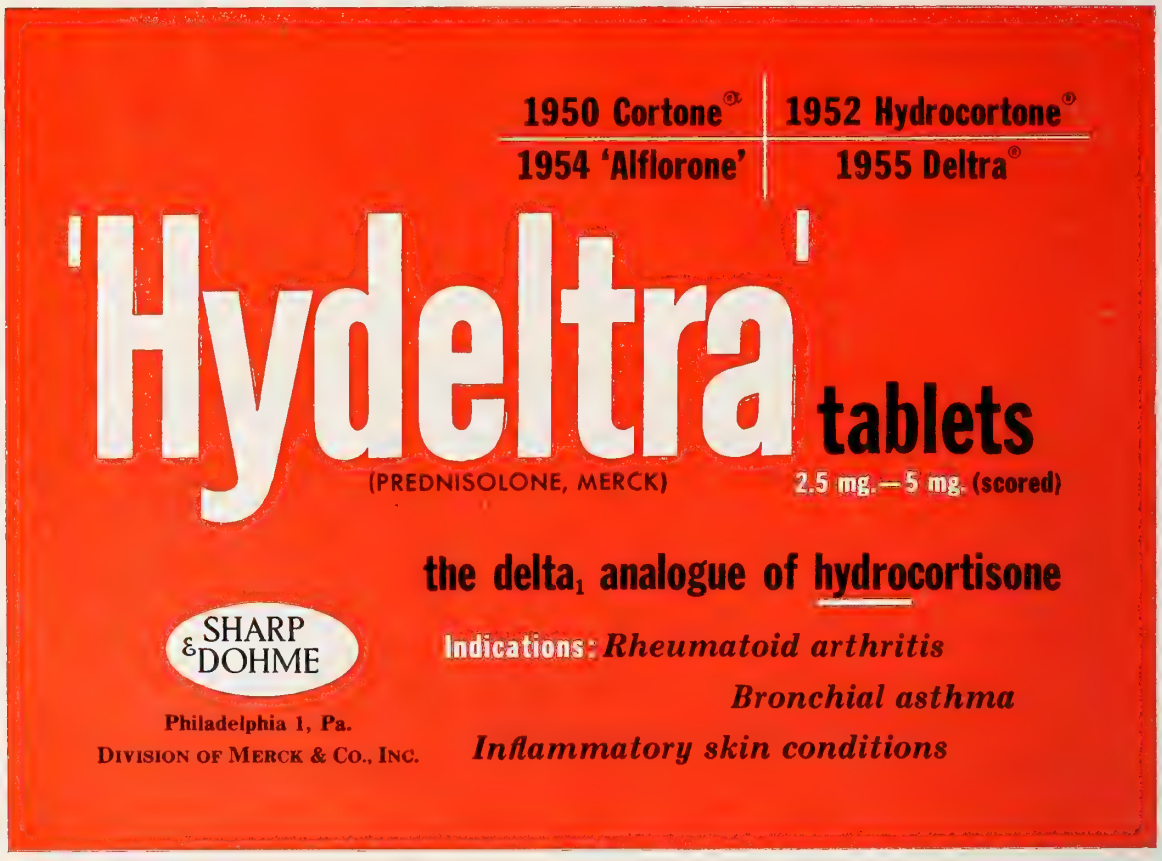
One of the advantages of a tumor registry such as that in Connecticut is that the statistical data that emerge offer a basis for a dispassionate analytical appraisal of accomplishments and failures down through the years. As a result of this study, it might be said that progress in the management of cancer of the colon and rectum is slow but real. Whatever the magnitude of improvement, it can scarcely be attributed to the fact that patients are now being admitted in an earlier stage of the disease than they were 10 years ago. Here, it apears that education has been ineffective. Rather, progress seems to have followed largely from the ability of more and more surgeons to perform radical operations with a steadily decreasing mortality. Although further progress may be anticipated along this line, any material change for the better in end results must await a plan for detecting more cases of cancer of the large bowel in its localized stage. This may not occur until the biologic characteristics of cancer in general, and of the colon and rectum in particular, are better understood. *Edward J. Ottenheimer, M. D. and Ashley W. Oughterson, M.D. Observations on Cancer of the Colon and Rectum in Conecticut. New England J. Med. April 7*, 1955.

American Urological Association award

The American Urological Association offers an annual award of $1000 (first prize of $500, second prize $300 and third prize $200) for essays on the result of some clinical or laboratory research in urology. Competition shall be limited to urologists who have been graduated not more than ten years, and to men in training to become urologists.

The first prize essay will appear on the program of the forthcoming meeting of the American Urological Association, to be held at the Statler Hotel, Boston, Massachusetts, May 28-31, 1956.

For full particulars write the Executive Secretary, William P. Didusch, 1120 North Charles Street, Baltimore, Maryland. Essays must be in his hands before December 1, 1955.



KNOX Protein Previews





New Study Shows Gelatine Restores Brittle Fingernails to Normal

Directions for making the Knox Gelatine drink in every package



Brittle, fragile or laminating fingernails are the bane of many a woman's existence. Yet this highly prevalent and distressing condition often has gone uncontrolled for lack of effective therapy. Now, you can promise these patients substantial relief in a large percentage of cases.

In a recent study[1] that confirmed previous work[2] Knox Gelatine was used to treat 36 women with fragile, brittle, laminating fingernails. The response was most gratifying. Except for three patients who discontinued the therapy, three diabetics, and two women who had congenital deformities, the splitting ceased and all other patients were able to manicure their nails to a full point by the time the study ended.

Optimal dosage proved to be one envelope (7 grams) of Knox Gelatine administered daily for three months. Improvement, however, was noted after the first month. If you would like more complete details of this work, just use the coupon.

1. Rosenberg, S. and Oster, K. A., "Gelatine in the Treatment of Brittle Nails," *Conn. State Med. J.* **19**:171-179, March 1955.
2. Tyson, T. L., *J. Invest. Dermat.* **14**:323, May 1950.

Chas. B. Knox Gelatine Company, Inc.
Professional Service Dept. IM-9
Johnstown, N. Y.

Please send me a reprint of the article by Rosenberg and Oster with illustrated color brochure.

YOUR NAME AND ADDRESS _

Neurosis plus

Medicines have a definite place in the treatment of the neurotic patient. If the first place, if there are any associated conditions, such as anemia, that require treatment they should certainly be treated. In addition, the judicious use of stimulants, antispasmodics, or sedatives may be beneficial. The patient must understand, however, that iron is for the anemia, not the nervousness, and that the other medicine is a kind of crutch that will be helpful in tiding him over some of the more troublesome symptoms until he can get well. The medicine is in no way curative and cannot relieve the patient of any of the responsibility that he and the doctor must share in the final treatment. I do not think it wise to give a placebo. As suggestion therapy it can have no bearing on the solution of the basic problems and can have only temporary effect, therefore, unless the patient was so mildly sick that he would have gotten well without any medicine. Furthermore, if the patient discovers he has been tricked he certainly will become angry and will no longer trust his doctor. Most injections of vitamins and hormones are given as a delaying action, postponing the time of real decision, hoping that the problem will work itself out. If the doctor is perfectly honest with himself and uses these as a means of keeping wholesome contact with a patient who otherwise might break off the treatment, they can have a real place in therapy. If not, such a procedure is a waste of money and materials, if nothing else. *W. T. Thompson, Jr., M.D. Office Management of the Neurotic Patient. West Virginia M.J. May,* 1955.

‹ ›

Health is people; it begins with the individual in his home and spreads to the family and the community in which he lives. Health is a quality of being—expressed in terms of wealth, contentment, and productivity. Public health is the summation of personal health and no community can be more healthful than the people who reside therein. Henry F. Vaughan, Dr. P.H., Am. J. Pub. Health, Mar., 1955.

Lederle

FOLBESYN*

Vitamins *Lederle*

A well-balanced, high-potency vitamin formula containing B-Complex and C

FOLBESYN provides B-Complex factors (including folic acid and B_{12}) and ascorbic acid in a well balanced formula. It does not contain excessive amounts of any one factor.

FOLBESYN Parenteral may be administered intramuscularly, or it may be added to various hospital intravenous solutions. It is useful for preoperative and postoperative treatment and during convalescence.

Dosage: 2 cc. daily. Each 2 cc. provides:

Thiamine HCl (B_1)	10 mg.
Sodium Pantothenate	10 mg.
Niacinamide	50 mg.
Ribloflavin (B_2)	10 mg.
Pyridoxine HCl (B_6)	5 mg.
Ascorbic Acid (C)	300 mg.
Vitamin B_{12}	15 micrograms
Folic Acid	3 mg.

FOLBEYSN is also available in tablet form, ideal for supplementing the parenteral dose.

LEDERLE LABORATORIES DIVISION AMERICAN Cyanamid COMPANY Pearl River, New York

*REG. U.S. PAT. OFF.

oducing Abbott's new
non-barbiturate hypnotic

Placidyl offers a gentle new therapy
or ordinary nervous insomnia.
It relaxes and calms the patient.
Tranquil sleep comes within 15 to 30
minutes—should last all night.
Placidyl does not force patients
nto sleep; rather, it *induces* them
o sleep naturally.
Hangover? Not a trace.
Even patients who take Placidyl
fter waking in the small hours
ise clear-headed and refreshed.
Side actions? Virtually none.
Not contraindicated in presence of
iver or kidney disease. Doses to
000 mg. show no effect on
ulse, blood pressure, respiration,
lood, or urine.
Profound hypnotic drugs remain
ustified for some insomnia patients.
But for those whom you wish to
ive a safer, more gentle source
f sleep . . . prescribe
his mild new product. Abbott

Not related to the barbiturates, bromides,
hloral hydrate, paraldehyde, etc. Avail-
ble in 500 mg. capsules, bottles of 100.
Adult dose for ordinary nervous insomnia
00 mg. at bedtime.

The Telephone

One of the chief causes of strain on the doctor and on his family is the 24 hour availability that the practicing physician so often feels honor bound to offer his patients. The days are long passed when an urgent message was carried to the doctor on horseback. The advent of the telephone and the automobile has changed all that. The present day physician or surgeon is available on the telephone by day or by night, and when he leaves his office he leaves his itinerary with his secretary so that he may be reached at a moment's notice in his hospital clinic, at a patient's home, or even at a public place. Indeed, it has been said that for a young doctor to be called out of church or from the movies, or perhaps from a scientific meeting is a good form of ethical advertising. Nevertheless, this fetish for availability can be carried too far and physicians and surgeons who have investigated in radio con trolled motor cars or who have arranged for rockets to be fired after them on the golf course are surely asking too much of their coronary arteries. *John Lister, M. D. The Doctor and his Telephone. New England J. Med. May* 26, 1955.

‹ ›

Auricular flutter

Approximately 90 per cent of the cases of auricular flutter are associated with organic heart disease. Hermann and Hejtmancik report a series of 82 cases of auricular flutter. Defining established flutter. Sixty-two per cent of those with established flutter as cases persisting over 72 hours, they list 50 as established flutter. Sixty-two per cent of those with established flutter were due to arteriosclerotic heart disease, 16 per cent to rheumatic heart disease, 6 per cent to thyrotoxicosis, 10 per cent miscellaneous, and 6 per cent were without organic heart disease. In the total group of 82 cases, approximately 65 per cent showed evidence of arteriosclerotic heart disease, 10 per cent rheumatic heart disease, 14 per cent thyrotoxic and miscellaneous forms of heart disease, and 9 per cent no evidence of organic heart disease. The examples of persistent flutter published as individual case reports have all been presented as having no organic heart disease. None of these cases was autopsied. *Julian B. Hoffman, M.D. and Max Pomerance, M.D. Chronic Auricular Flutter. Ann. Int. Med. April* 1955.

Not so smart

It need never be feared that one man will become so knowledgeable that none other will be able to outdistance him. In spite of the intellectual accomplishments of advanced thinkers in the fields of art or science, the fact remains that man's concepts are both created and limited by his five senses. Without them the whole structure of centimeter-gram-second knowledge would collapse. A dog, a bird, or a bee, on the other hand, seems at times to have access to other channels of knowledge. Although scientists have been able to build bombs that will blast sizable areas of the earth's surface, they cannot construct a honeycomb, and even Picasso cannot produce anything so lovely as a damask rose. *Editorial. Sturm and Drang. New England J. Med. March* 3, 1955.

‹ ›

A close one for T.R.

The only narrow escape I met with was not from one of those dangerous African animals but from a grizzly bear. It was about 24 years ago. I had wounded the bear just at sunset, in a wood of lodge-pole pines and, following him, I wounded him again, as he stood on the other side of a thicket. He then charged through the brush, coming with such speed and with such an irregular gait that, try as I would, I was not able to get the sight of my rifle on the brain-pan, though I hit him very hard with both remaining barrels of of my magazine Winchester. It was in the days of black powder, and the smoke hung. After my last shot, the first thing I saw was the bear's left paw as he struck at me, so close that I made a quick movement to one side. He was practically dead, however, and after another jump and while in the very act of trying to turn to come at me, he collapsed like a shot rabbit. *The Works of Theodore Roosevelt, An Autobiography. Scribner's MCMXXV.*

‹ ›

Good health cannot be forced upon the public. We can, however, create an environment in which people will study their health needs and work out ways of doing what they want to do with what they have. This is true health education and the essence of democracy. Leroy E. Burney, M.D., Am. J. Pub. Health, Feb., 1955.





CIN

TETRACYCLINE *Lederle*



DOSAGE FORMS FOR EVERY NEED...A CHOICE OF POTENCIES!

New!

ACHROMYCIN SF

ACHROMYCIN WITH STRESS FORMULA VITAMINS



dry-filled sealed capsules—a Lederle exclusive! No oil, no paste, tamper-proof. More rapidly and completely absorbed. Stress vitamin formula as suggested by the National Research Council. Prescribe ACHROMYCIN SF for prompt control of infection and rapid patient recovery, particularly in prolonged illness. *Capsules of 250 mg.*

Also available: ACHROMYCIN SF Oral Suspension: 125 mg. per teaspoonful (5 cc.), 2 oz. bottle.

Lederle

LEDERLE LABORATORIES DIVISION *AMERICAN Cyanamid COMPANY* Pearl River, New York

*REG. U. S. PAT. OFF.

WE CORDIALLY INVITE YOUR INQUIRY for application for membership which affords protection against loss of income from accident and sickness (accidental death, too) as well as benefits for hospital expenses for you and all your dependents.



SINCE 1902

ALL PREMIUMS COME FROM PHYSICIANS SURGEONS DENTISTS

ALL BENEFITS GO TO

$4,500,000 ASSETS
$22,500,000 PAID FOR BENEFITS

PHYSICIANS CASUALTY AND HEALTH ASSOCIATIONS
OMAHA 2, NEBRASKA

Functional dyspnea

Functional dyspnea should be easily recognizable, especially when of the "sighing" type because such patients show nothing abnormal on physical examination and often display characteristic deep sighs. They complain of being unable to get enough air when they have overventilated and have actually inhaled three or four times as much air as they need. Furthermore, they feel short of breath without cause at rest. When an organic cardiac is breathless at rest he obviously is very sick and is likely to show ample evidence of organic heart disease whereas the functional cases appear quite well. Another misinterpretation of the complaint of breathlessness is in confusing cardiac with bronchial or pulmonary dyspnea. Many patients with emphysema or pulmonary fibrosis are given digitalis and other cardiac therapy on the basis that they have heart failure. The character of the breath sounds, the prolonged expiration with squeaking disseminated rales, the emphysematous appearance of the chest on inspection and on x-ray examination, and the normal size of the heart and other clinical features are generally adequate to identify the true nature of the disability. Discontinuing digitalis, administering medications like ephedrine and other measures directed at the pulmonary problem often prove to be rewarding. *Samuel A. Levine, M.D. Pitfalls in the Care of Cardiacs. Ann. Int. Med. June* 1955.

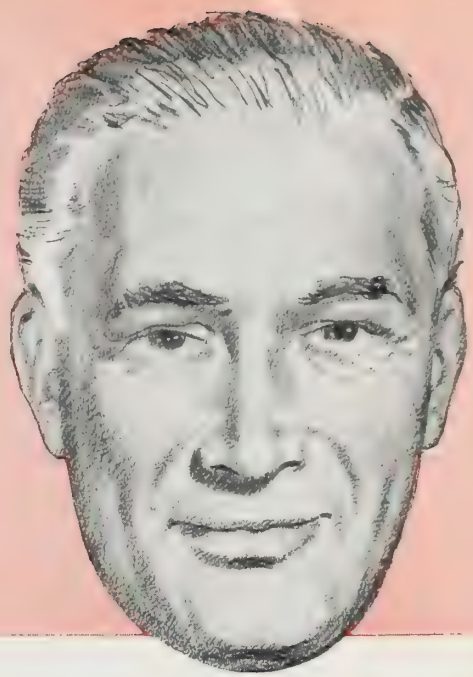
‹ ›

If we are to discover the hitherto unknown and untreated cases of tuberculosis, we must direct our clinic services and X-ray surveys more intelligently than we have in the past . . . In mass radiography the percentage of cases found increases sharply from 40 years of age and over. It seems obvious that it is among the older age groups and particularly older men that we must concentrate in case finding. Paul S. Phelps, M.D., The John N. Wilson Memorial Lecture, April 30, 1954.

‹ ›

It is great to have friends when one is young, but indeed it is still more so when you are getting old. When we are young, friends are, like everything else, a matter of course. In the old days we know what it means to have them. — *Edvard Grieg*

In this...
"the Commonest Disease of Civilized Man"



- In hypertension, management can now be started in the earliest stages . . . to retard progression, with the goal of prolonging useful life.

- Fully one half of all cases of mild, labile hypertension can be controlled with simple Rauwiloid therapy.

- Rauwiloid accomplishes what mere sedation cannot . . . the patient is spared the reaction to tension situations . . . without somnolence, without clouded sensorium, without change in alertness.

- The feeling of well-being engendered by Rauwiloid may become manifest as soon as 24 to 48 hours after the first dose. Its antihypertensive effect becomes apparent in two to three weeks.

- In the face of tension-producing stimuli, Rauwiloid, through its sedative and bradycrotic properties, provides tranquil equanimity.

- Its dosage schedule is uncomplicated, definite, easy to follow: Merely 2 tablets at bedtime. For maintenance, 1 tablet usually suffices. No contraindications.

Rauwiloid® *First Thought IN HYPERTENSION*

Riker LABORATORIES, INC., LOS ANGELES 48, CALIF.

for CHILDREN with EDUCATIONAL and ADJUSTMENT PROBLEMS

. . . a private resident school for children of average or superior intelligence whose psychological difficulties impair their learning abilities and school progress.

. . . enrolling children from seven to fourteen years of age. Coeducational. Small classes. Remedial reading. Brochure on request.

. . . provides a program of education with psychotherapy.

. . . out-patient psychiatric evaluation and consultation for children.

ANN ARBOR SCHOOL

A. H. Kambly M.D., Director

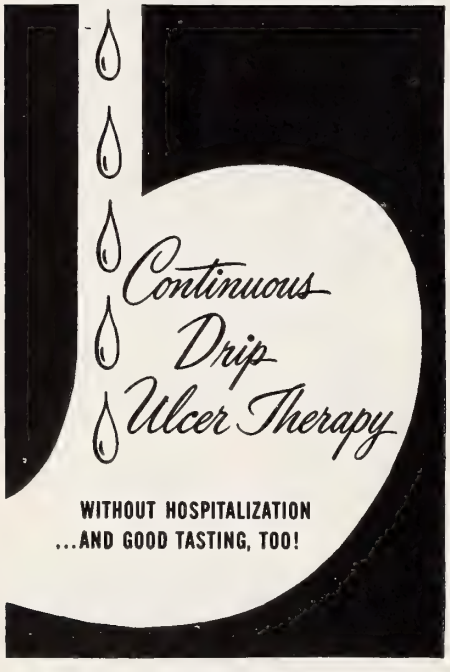
411 First National Building Ann Arbor, Mich.

Surgery for cancer

Patients who have undergone an operation for cancer may require extensive psychologic rehabilitation. Beliefs in irremediable body injury and unacceptability to others are frequently responsible for unnecessary restriction of activities. They are reinforced by postoperative complications and psychosomatic symptoms secondary to anxiety or depression. The spouse may greatly help or hinder rehabilitation. A good patient-physician relationship, beginning with the initial diagnostic examination, is the patient's best guarantee against the development of crippling beliefs and their expression in unnecessary restriction of activities. *Arthur M. Sutherland, M.D. Psychologic Barriers to Rehabilitation of Cancer Patients. Postgrad. Med. June* 1955.

‹ ›

More and more clearly every day, out of biology, anthropology, sociology, history, economic analysis, psychological insight, plain human decency, and common sense, the necessary mandate of survival that we shall love all our neighbors as we do ourselves, is being confirmed an reaffirmed. — *Ordway Tead*



HORLICKS CORPORATION
Pharmaceutical Division
RACINE, WISCONSIN

Nulacin

A recent clinical study* of 46 ambulatory nonhospital patients treated with Nulacin† and followed up to 15 months describes the value of ambulatory continuous drip therapy by this method. Total relief of symptoms was afforded to 44 of 46 patients with duodenal ulcer, gastric ulcer and hypertrophic gastritis.

The delicately flavored tablets dissolve slowly in the mouth (not to be chewed or swallowed). They are not noticeable and do not interfere with speech.

Nulacin tablets are supplied in tubes of 25 at all pharmacies. Physicians are invited to send for reprints and clinical sample.

*Steigmann, F., and Goldberg, E.: Ambulatory Continuous Drip Method in the Treatment of Peptic Ulcer, Am. J. Digest. Dis. *22*:67 (Mar.) 1955.

†Mg trisilicate 3.5 gr.; Ca carbonate 2.0 gr.; Mg oxide 2.0 gr.; Mg carbonate 0.5 gr.

SULFADIAZINE
SULFAMERAZINE
SULFAMETHAZINE

triple sulfas

METH-DIA-MER SULFONAMIDES

unexcelled among sulfa drugs . . . for economy

Triple Sulfas are among the most economical of sulfa drugs. Compared with certain therapeutic agents, they are a bargain indeed. Despite their low cost, they are notable in many ways—for their high potency, wide spectrum, safety, minimal side effects, and high blood, plasma, spinal fluid and tissue levels. Triple Sulfas, alone or in combination with other therapeutic agents, are available from leading pharmaceutical manufacturers under their own brand names. *Not all sulfas are Triple Sulfas.* Ask any medical representative about the Triple Sulfa products his company offers!

AMERICAN Cyanamid COMPANY
FINE CHEMICALS DIVISION
30 ROCKEFELLER PLAZA, NEW YORK 20, N. Y.



HOW Wyeth OFFERS TRIPLE SULFAS

Suspension SULFOSE® contains 0.167 gm. of each of the Triple Sulfas per teaspoonful (5 cc.). It provides sustained high blood levels. Suspension SULFOSE is effective, convenient, economical, unusually palatable, remarkably stable. It is indicated for a wide variety of systemic, gastrointestinal, and urinary tract infections. Packaged in bottles of one pint. Also available as Tablets SULFOSE.



the gift unusual
— dressed Quail —

Give oven-ready and frozen Quail for Xmas and you send the extraordinary gift. This is the rare treat that will mark you as an epicure of fine food and thoughtful gifts.
We will deliver these full-sized quail in dry ice to any place in the U. S. for $28.00 per doz. prepaid. Minimum shipment 1 doz. birds. Shipments made each Tuesday from Sept. to April. FREE recipes with each order. Send us your gift list now! Check with order, please.

LOWRANCE QUAIL FARM

1730-MJ Picher **Joplin, Mo.**

Phone: Mayfair 3-3643

Dysphagia

The results of physical examination of patients complaining of dysphagia are likely to be essentially negative except for evidence of loss of weight. However, a valuable method of physical diagnosis which often is neglected is the simple expedient of watching the patient drink a few swallows of water. Frequently, more can be learned from this simple observation than from any verbal description of the symptoms given by the patient. *O. Theron Clagett, M.D. Esophageal Carcinoma. Postgrad. Med. June* 1955.

« »

Inmates of institutions are often more likely to have active tuberculosis because of their previous social status and living habits. They are also likely to acquire tuberculosis from close contact in the institution. Among inmates of mental hospitals, the prevalence of undiscovered active tuberculosis is particularly high, being in the neighborhood of 30 per 1,000 inmates examined on a first screening. The prevalence of tuberculosis increases with age; consequently case-finding opportunities among the elderly should never be overlooked. Robert J. Anderson, M.D., Nat. Tuberc. A. Tr., 1954.

1950 Cortone® | 1952 Hydrocortone®
1954 'Alflorone' | 1955 Deltra®

'Hydeltra' tablets
(PREDNISOLONE, MERCK) 2.5 mg.—5 mg. (scored)

the delta$_1$ analogue of hydrocortisone

SHARP & DOHME
Philadelphia 1, Pa.
Division of Merck & Co., Inc.

Indications: *Rheumatoid arthritis*
Bronchial asthma
Inflammatory skin conditions



Trasentine®-Phenobarbital

- Inhibits Parasympathetic Activity
- Relaxes Smooth Muscle Directly
- Exerts Local Anesthetic Effect on G-I Mucosa
- Sedates the Patient

Without Atropine Side Effects

Each tablet contains 50 mg. Trasentine hydrochloride and 20 mg. phenobarbital.
Also available: Trasentine hydrochloride Tablets, 75 mg.

Trasentine® hydrochloride
(adiphenine hydrochloride CIBA)



2/20618M

C I B A *Summit, N. J.*

Mercy Hospital Institute of Radiation Therapy

The Henry Schmitz Medical Group

For Appointment
Victory 2-4700, Ext. 170 or RAndolph 6-4444

Herbert E. Schmitz, M.D., *Director*
Peter A. Nelson, M.D., *General Oncology*
Henry L. Schmitz, M.D., *Internal Medicine*
Janet Towne, M.D., *Gynecology*
Robert L. Schmitz, M.D., *General Surgery*
John F. Sheehan, M.D., *Pathologist*
Charles J. Smith, M.D., *Gynecology*
Charles S. Gilbert, M.D., *Internal Medicine*
William F. Cernock, M.D., *Internal Medicine*
Fred W. Eims, *Physicist*
Miss Hilda Waterson, R.N.
Helen Hansen, *Social Service*

COMPLETE TUMOR THERAPY
Including
SUPERFICIAL X-RAY THERAPY
DEEP X-RAY THERAPY up to 1,000 K.V.
RADIUM THERAPY

Daily Consultation at Institute
Tumor Clinic—Mercy Free Dispensary—Tuesday at 9 a. m.
Tumor Conference — J. B. Murphy Auditorium — Friday at 1 p. m.

specify

LEDERLE

POLIOMYELITIS IMMUNE GLOBULIN

(human)

Lederle

For the modification of measles and the prevention or attenuation of infectious hepatitis and poliomyelitis.

LEDERLE LABORATORIES DIVISION
AMERICAN Cyanamid COMPANY Pearl River, New York

1950 Cortone® | **1952 Hydrocortone®**
1954 'Alflorone' | **1955 Deltra®**

'Hydeltra' tablets

(PREDNISOLONE, MERCK)

2.5 mg.—5 mg. (scored)

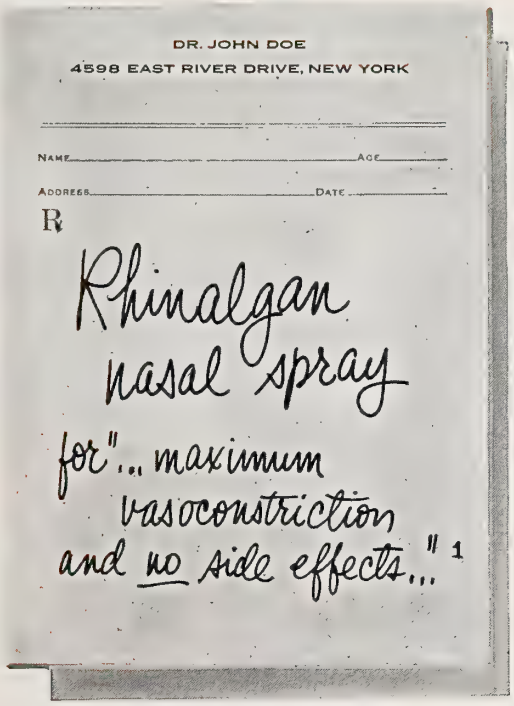
the delta$_1$ analogue of hydrocortisone

SHARP & DOHME

Philadelphia 1, Pa.
DIVISION OF MERCK & CO., INC.

Indications: *Rheumatoid arthritis*
Bronchial asthma
Inflammatory skin conditions

WHENEVER RAUWOLFIA SERPENTINA OR CHLORPROMAZINE CAUSES NASAL CONGESTION



RHINALGAN® nasal spray

NOT "JUST ANOTHER" DECONGESTANT!

Make it a habit to prescribe Rhinalgan Nasal Spray to prevent nasal congestion whenever you prescribe chlorpromazine or rauwolfia serpentina preparations. *1. N. Y. Phys., 34:14, 1950.*

DOHO
CHEMICAL CORP.
100 VARICK ST.
NEW YORK 13, N.Y.

LEADERS IN E.N.T. PRODUCTS SINCE 1915

PRINTED IN U.S.A.

BELLEVUE PLACE

For

NERVOUS and MENTAL DISEASES

★

Edward Ross, M.D., Medical Director
BATAVIA PHONE
ILLINOIS BATAVIA 1520

THUMBSUCKING

since infancy caused this malocclusion.



THUM TRADE MARK

THUM broke the habit and teeth returned to normal position.

ACCEPTED FOR ADVERTISING IN PUBLICATIONS OF THE AMERICAN MEDICAL ASSOCIATION

Get Thum at your druggist or surgical dealer.
Prescribed by physicians for over 20 years.

Classified Ads

RATES FOR CLASSIFIED ADVERTISEMENTS—For 30 words or less: 1 insertion, $3.00; 3 insertions, $8.00; 6 insertions, $14.00; 12 insertions, $24.00; from 30 to 50 words: 1 insertion, $4.00; 3 insertions, $10.50; 6 insertions, $20.00; 12 insertions, $30.00. Extra words: 1 insertion 10c each; 3 insertions, 25c each; 6 insertions, 40c each; 12 insertions, 50c each. A fee of 25c is charged for those advertisers who have answers sent care of the Journal. Cash in advance must accompany copy.

FOR SALE: Spencer microtome complete with freezing attachment. Price $175.00. Call Central 6-1565 or Mansfield 6-2388. 9/55

FOR SALE—Hospital, about 65 miles S.W. of Chicago Small Unit—53 Patients. Could be used as mental sanitarium. Price $150,000.00. Cicero Realty Co. 407 S. Cicero Avenue. AUstin 7-2162.

WANTED—Rural Practitioner for Patoka, Illinois Population 600; large trading area. May practice to replace present physician while in military service. Write to C. D. Martin, Patoka, Illinois.

FOR RENT—One seven room air conditioned physicians suite, suitable for 1 or 2 doctors. One 4 room dental suite in well established medical center. 110 bed hospital, open staff. Ample parking. Doctor owner. Contact Mrs. Martha Robinson, 122½ N. Avenue A, Canton, Ill.

FOR SALE: Excellent opportunity for stepping into readymade practice in fully equipped office. Small southern Illinois town desperately in need of doctor. Office established. Widow will make very reasonable terms on office fixtures, etc. No other doctor in 10 mile radius. Mrs. V. H. Burkhart, Hurst, Illinois.

Do You Know ? ? ?

THE SPECIAL DISABILITY PLAN

AVAILABLE TO MEMBERS OF

THE ILLINOIS STATE MEDICAL SOCIETY

Provides Benefits up to . .

$5000. ACCIDENTAL DEATH AND DISMEMBERMENT

$100. PER WEEK FOR TOTAL LOSS OF TIME as the result of either Sickness or Accident.

$15. DAILY HOSPITALIZATION for up to 90 days as the result of either Sickness or Accident.

Plus . . .

Optional 5 Year Sickness Coverage
No reduction in benefits because of other insurance
Full benefits to age 70 at same cost
(All Benefits Subject to Provisions of the Policy)

FOR ALL THE FACTS - - -
Write or Telephone

PARKER, ALESHIRE & COMPANY

175 W. JACKSON BOULEVARD
Chicago 4, Ill. WAbash 2-1011

Reassurance

Inquiry revealed that a number of women, by no means the majority, respond best to advice and reassurance of the authoritative kind. They are more likely to be European than American born. They have become imbued with a deep feeling that the voice of authority emanates only from people who behave like their strict fathers and the other strong male characters of their childhood. The physician learns in time to adapt his manner of giving advice to meet such needs. Our investigations have shown particularly the value of this kind of flexibility. *David M. Levy, M.D. Advice and Reassurance. Briefs. Jan.* 1955.

Widow bite

The treatment of black widow spider includes parenteral and oral calcium, opiates, fluids, oxygen, and antivenin. *Richard R. Grayson, M.D. Black Widow Spider Bites. Missouri Med. May* 1955.

THE KEELEY INSTITUTE
DWIGHT, ILLINOIS

Treating alcoholism and other problems of addiction.
REGISTERED BY THE AMERICAN MEDICAL ASSOCIATION—
MEMBER AMERICAN HOSPITAL ASSOCIATION.

Table of Contents

OCTOBER, 1955
Vol. 108, No. 4

Editor
Harold M. Camp
Monmouth, Illinois

Associate Editor
Theodore Van Dellen
Chicago, Illinois

Business Manager and Managing Editor
Mr. L. E. Malley
185 N. Wabash Avenue
Chicago 1, Illinois

Business Office
185 N. Wabash Avenue
Chicago 1, Illinois

Editorial Office
Medical Arts Building
Monmouth, Illinois

Send original articles and membership correspondence to Harold M. Camp, Monmouth, Ill.

Send changes in the mailing list to Managing Editor, 185 N. Wabash Ave., Chicago 1, Ill.

Subscription price of this JOURNAL to persons not members of the Illinois State Medical Society is $4.00 per year, in advance, postage prepaid, for the United States, Cuba, Puerto Rico, Philippine Islands, Hawaiian Islands and Mexico. $5.00 per year for all foreign countries included in the postal union. Canada, $4.50. Single current copies 50 cents. By mail, 60 cents.

ORIGINAL ARTICLES

Venous Thrombosis. Alton Ochsner, M.D., New Orleans, La. 213
The Practicing Physician's Role in the Control of Poliomyelitis. Leonard M. Schulman, M.D., M.Sc., Minneapolis, Minn. 218
Collateral Cardiac Circulation. Alene Bledsoe, M.D., Marshfield, Wisconsin 220
Aneurysm of the Splenic Artery. C. Colangelo, M.D., Chicago .. 223
Uncommon Sites of Herpes Zoster. F. Garm Norbury, M.D., F.A.C.P., Jacksonville 226
Management of the Pyodermas. Hilliard M. Shair, M.D., Quincy .. 228
Gastro-Intestinal Allergy. J. B. Seagle, Urbana 231
An Unusual Complication of Sigmoid Volvulus. Thomas W. Samuels, M.D., Chicago. (Cook County Hospital Case Record) 236

PATHOLOGY CONFERENCES

Congenital Stenosis of the Neck of the Urinary Bladder. William J. Baker, M.D., and Edwin F. Hirsch, M.D., Chicago 238

EDITORIALS

A century of gynecology 241
Drugs in epilepsy 241
Interstate Postgraduate Medical Association 241
Conference of Mental Health Representatives 242
Interest in medical history 242
Alien physicians studying in the United States 243
Statutes of public health significance enacted by 69th General Assembly 243
Book reviews 58A

MEDICAL ECONOMICS

Insurance for Freedom in Education. John R. Wolff, M.D., Chicago 246

THE P.R. PAGE 248

CORRESPONDENCE

Clinics for crippled children listed for November 250
Cancer lecture series 250
University of Michigan Medical School Postgraduate Conference 251
Annual session of Illinois Chapter, Academy of General Practice 251
Industrial health P.G. courses 251
Fiske Fund Prize Dissertation 1955 252
Medical reservists to earn credit points at military surgeons meeting 252

NEWS OF THE STATE 252

Entered as Second-Class Matter November 12, 1952 at the Post Office, Mendota, Illinois, under the Act of March 8, 1879. Acceptance for mailing at special rate postage provided for in section 1102, Act of October 8, 1917, authorized July 15, 1918. Printed monthly by The Wayside Press, Mendota, Illinois. Office of Publication, 1501 W. Washington Road, Mendota, Illinois. POSTMASTER — Return undeliverable copies under form 3579 to 1501 W. Washington Road, Mendota, Illinois.



he's heard the call for . .



The
ILLINOIS
Medical Journal



Official Journal of The Illinois State Medical Society

OCTOBER 1955
VOL. 108 NO. 4

Venous Thrombosis

Alton Ochsner, M.D., New Orleans, La.

VENOUS thrombosis, in spite of tremendous increase in the knowledge of factors influencing clotting, continues to be a serious hazard to many patients. It is of significance and is of interest to all clinicians. Whereas venous thrombosis has previously been considered as being of importance only in older persons, it is now recognized that venous thrombosis occurs in the first year of life as well as in older persons. Although it is relatively rare in children, the fatality incidence is extremely high (84 per cent). Among 180,300 children admitted to the Charity Hospital in New Orleans between 1938 and 1950, there were 37 who developed thromboembolism, an incidence of 21 per 100,000 admissions. The fatality incidence, however, was 17 per 100,000 admissions.

Venous thrombosis occurs frequently enough to demand the serious attention of all clinicians. It occurs approximately once in every 500 general hospital admissions. Between 1938 and 1950 there were 627,868 admissions to the Charity Hospital in New Orleans and thromboembolism was diagnosed in 1,223 cases or one in every 529 admissions. The incidence of fatal pulmonary embolism was one in every 1,361 admissions, but undoubtedly the incidence of fatal pulmonary embolism was higher than this because in only 30 per cent of the fatal cases was an autopsy performed. Had 100 per cent autopsy incidence been obtained, there would have been an expected incidence of one in every 573 admissions. Although thromboembolism is usually considered more frequently by surgeons because of its postoperative incidence, it is in no way limited to patients who have been subjected to operation. In the Charity Hospital series there were 106 postoperative fatal emboli of which 72 were confirmed at autopsy. If autopsy had been performed in all cases, the expected number would have been 212. Thus, the actual incidence was one in every 1,575 operations and the expected incidence was one in every 878 operations. However, the incidence of fatal pulmonary embolism was actually higher in non-surgical patients than in surgical patients. The frequency was one in every 1,247 patients with an expected incidence of one in every 502 patients. It is thus seen that venous thrombosis and its possible complications are of real importance to all physicians.

The incidence of venous thrombosis has increased at the Charity Hospital since 1938. In the period 1938 to 1942, the incidence was 131

From the Department of Surgery, School of Medicine, Tulane University and the Ochsner Clinic, New Orleans, La.

Oration in Surgery presented at the 115th Annual Meeting of Illinois State Medical Society, Chicago, May 18, 1955.

per 100,000 admissions; in the period 1942 to 1946, it was 194; and in the period 1946 to 1950, it was 241. Although there has been an increase in the incidence of fatal pulmonary emboli, the increases have not been as great. The respective numbers for the same periods were 61, 68, and 89.

Thromboembolism occurs more frequently in men (281 per 100,000 admissions) than in women (238 per 100,000 admissions). Fatal pulmonary embolism is twice as frequent in men (140) as in women (70). On the other hand, peripheral thrombosis occurs more frequently in women (139 per 100,000 admissions) than in men (98 per 100,000 admissions). The higher incidence of pulmonary embolism in men undoubtedly is due to the fact that men more frequently have coronary thrombosis and other types of heart disease which may be complicated by pulmonary embolism. Peripheral thromboses, on the other hand, occur more frequently in women because of the relatively high incidence of peripheral thrombosis in obstetrical patients.

The incidence of venous thrombosis varies according to the hospital service. In the Charity Hospital the highest incidence was on the gynecologic service (348 per 100,000 admissions) followed in frequency by surgery (269), medicine (261), urology (220), and obstetrics (106). The incidence of *peripheral* thrombosis was highest on the gynecologic service (195), followed by surgery (152), urology (123), obstetrics (87), and medicine (75). Pulmonary embolism, however, was highest on the medical service (208) followed in frequency by gynecology (152), surgery (106), urology (96), pediatrics (89), and obstetrics (19). The reason for the high incidence of pulmonary embolism on the medical service undoubtedly was that many of the patients were cardiacs in whom phlebothrombosis is likely to develop. On the other hand, the low incidence of pulmonary embolism in obstetrical patients is due to the fact that these patients usually have true phlegmasia alba dolens, or thrombophlebitis, in which the thrombus is firmly attached and does not become detached to cause pulmonary embolism.

Thromboembolism is a serious disease as evidenced by the Charity Hospital statistics. The case fatality rate was 40 per cent. Of the 1,223 patients observed, 489 died. Case fatality rates according to the various services were as follows: pediatrics, 84, medicine, 67, urology, 40, gynecology, 27, surgery, 26, and obstetrics, 8. The relatively low fatality rate on the obstetrical service is undoubtedly due to the fact, as mentioned previously, that obstetrical patients who develop venous thrombosis usually have thrombophlebitis in which the clot is firmly attached and does not become detached with the production of pulmonary embolism. The high case fatality incidence on the pediatric service is due to the fact that venous thrombosis in children is usually associated with infection and as a result of suppurative thrombophlebitis, septic emboli get into the blood stream with the production of fatal sepsis. The high fatality incidence on the medical service is due to the high incidence of pulmonary embolism in individuals who are cardiacs. On the other hand, the relatively low case fatality rate on the surgical service is, we believe, due to the fact that surgeons generally have been more interested in venous thrombosis and have treated the condition somewhat better than have the other services.

For some time we have been convinced that it is necessary to differentiate between two types of venous thrombosis and, unless one does make this differentiation, not only will there be confusion concerning the type of venous thrombosis but also relatively little will be accomplished as regards adequate therapy. We differentiate between thrombophlebitis and phlebothrombosis. They are different in many respects and cannot be considered as being the same lesion. In fact, they have only one thing in common, namely, a clot within the vein. Thrombophlebitis, or phlegmasia alba dolens, is probably the most widely recognized of all venous thromboses because of the relative ease with which the diagnosis can be made. It is usually caused by perivenous lymphangitis resulting either from actual invasion of the perivenous lymphatics by microorganisms or by toxins. Perivenous lymphangitis produces inflammatory changes within the vein which result in the production of a white thrombus which is firmly attached to the vein wall. Unless there is suppuration to produce liquefaction, the clot does not become detached and there is no danger of pulmonary embolism. In the presence of suppuration, however, which is relatively rare,

liquefaction of the clot can occur and septic emboli can be broken off. The patient with phlegmasia alba dolens, or thrombophlebitis, is usually ill. He has fever and pain, there is swelling of the extremity, and the extremity is frequently of a white color as designated by the term alba in phlegmasia alba dolens. The swelling of the extremity is due to edema; the pain and whiteness of the extremity are, as we have demonstrated, due to ischemia. As mentioned previously, in thrombophlebitis the clot is firmly attached and there is little or no danger of pulmonary embolism. However, unless the condition is adequately treated early in the course of the disease, persistent sequelae occur which are disabling for months and frequently for the rest of a patient's life. The treatment of thrombophlebitis is quite satisfactory and consists of overcoming the ischemia produced by vasoconstriction of the arterioles resulting from impulses originating in the thrombophlebitic segment which are carried by the sympathetic nerves to the arterioles. Vasodilatation of the arterioles is secured by anesthetization of the regional sympathetic ganglia. Following the introduction of procaine, or other suitable local anesthetic agents, into the regional lumbar ganglia, there is prompt subsidence of the clinical manifestations in a patient with thrombophlebitis. Pain disappears, the extremity becomes warm and resumes its normal color, fever subsides, and there is a rapid disappearance of the edema. Generally within a period of 7 to 10 days the patient is completely relieved and persistent sequelae do not develop.

In the relatively rare case of suppurative thrombophlebitis, which occurs not infrequently following puerperal sepsis in which there is a suppurative thrombophlebitis of the pelvic veins, it is necessary to perform vein ligation on the cardiac side of the area of venous involvement because if this is not done infected emboli become loosened as a result of the suppurative process, are carried into the vascular system, and produce sepsis. Mortality rates following suppurative thrombophlebitis of the pelvic veins previously were prohibitively high, approximately 80 per cent. Now, however, by ligation of the inferior vena cava above its bifurcation and ligation of the two ovarian vessels, detachment of septic emboli and their transportation into the vascular system can be prevented. The mortality rate now is less than 5 per cent.

In phlebothrombosis there is no venous lesion originally. In contradistinction to thrombophlebitis in which the venous clot is due to alterations in the venous endothelium, the vein in phlebothrombosis is normal. The clot which is a coagulation or red thrombus is in all probability due to two factors, increased blood coagulability and venous stasis. The former, which is a protective phenomenon, results from tissue injury which may be accidental or operative, or may be caused by invasion of tissue by neoplastic disease or infection. Venous stasis, which usually is greatest in the veins of the lower extremities, is due to many factors, decreased muscular contraction, diminished arterial blood flow, increased intra-abdominal tension, and intrathoracic negative pressure which is less than normal. The thrombus in phlebothrombosis is the same type of clot that occurs in a test tube when blood is withdrawn from the body and allowed to clot. The clot is not attached and can become detached just as readily as the clot in a test tube becomes detached from the wall of the test tube when the test tube is inverted. Because of this the patient with phlebothrombosis is a potential fatality and there is a possibility and a likelihood of the clot becoming detached at any time producing either non-fatal pulmonary infarction or fatal pulmonary embolism.

In contradistinction to thrombophlebitis, the patient with phlebothrombosis has either no clinical manifestations whatsoever or, at most, minimal manifestations. In 40 per cent of our cases of fatal pulmonary embolism there was no antecedent evidence of a clot being present, the first evidence of the phlebothrombosis being the fatal episode. Fortunately, most cases of phlebothrombosis have some clinical manifestations which, if recognized, are of diagnostic importance. These are, however, extremely minimal. Not infrequently there is a sense of impending disaster, a premonition by the patient that something is about to happen. Although it is difficult to explain why this occurs, it is real and whenever a patient becomes frightened about what might happen, without any apparent reason for this feeling, the physician should be on his guard because of the possibility of the presence of phlebothrombosis. A tachycardia out of propor-

tion to anything else is of significance. This is frequently described as a "stepladder pulse". Occasionally there is vein tenderness, tenderness of the calf muscles of the leg, tenderness on the plantar aspect of the foot or along the course of the deep veins of the thigh. Pain in the calf or in the popliteal space when the foot is forcibly dorsiflexed (Homans' sign) is of diagnostic significance. If any of these manifestations are present, it is our belief that one is obligated to institute measures to prevent detachment of a clot which is so loosely attached to the vein wall. This can be satisfactorily accomplished only by ligating the venous trunk on the cardiac side of the thrombus. The administration of anticoagulants to such an individual will prevent the propagation of more thrombi but will certainly not prevent the detachment of the clot that is already formed and actually can do harm by lulling the physician into a false sense of security because of his belief that he is treating the patient satisfactorily when in reality nothing is being done to prevent the detachment of the loosely attached clot and its being carried to the heart and lung with the production of either a non-fatal or fatal pulmonary embolism.

It is our practice in all cases with suspected phlebothrombosis to ligate either the superficial femoral veins bilaterally or to perform an inferior vena caval ligation. If the patient has had a pelvic disease or has been subjected to a pelvic operation, then we do a preliminary inferior vena caval ligation extraperitoneally. If, however, there is no reason to suspect involvement of the pelvic veins, both superficial femoral veins are exposed under local analgesia and, if no clot is found in either, they are ligated at their junction with the common femoral. If, however, a clot is found extending up to the junction of the superficial femoral with the deep femoral, as much of the clot distally is removed as can be, the vein is closed and the inferior vena cava is ligated just above the bifurcation. Whereas, previously we attempted to aspirate any clot extending proximally into the common femoral vein, we now feel that this is not without danger. We have had 11 patients in whom superficial femoral vein ligations had been done but in whom subsequently embolism occurred as a result of thrombi developing above the ligation of the superficial femoral vein.

Because venous thrombosis, particularly phlebothrombosis, occurs so insidiously and because the latter is frequently present without producing any clinical manifestations, it is desirable to prevent venous thrombosis whenever possible. Much can be accomplished by overcoming those factors which predispose to phlebothrombosis, such as minimization of operative trauma, because phlebothrombosis is undoubtedly due to a combination of factors, an increased clotting tendency secondary to tissue injury regardless of the cause, and the slowing of the blood stream, the latter determining the site of the phlebothrombosis. Early ambulation, active contraction of the skeletal muscles of the lower extremity against resistance while the patient is in bed, deep breathing exercise, and avoidance of tight abdominal bandages will tend to overcome venous stasis and, in this way, decrease the incidence of phlebothrombosis. However, in spite of all of these prophylactic measures, venous thrombosis still occurs. Unfortunately, the presently available anticoagulant agents are too dangerous to be used routinely in all patients. It is because of this that several years ago we attempted to find an agent which could be used safely but which might be effective in preventing intravascular clotting. Because we found by in vitro experiments that alpha tocopherol when combined with calcium exerted antithrombic activity, we have used this combination as a prophylactic measure for the past few years. Although the results are not as perfect as we would like to have them, we are of the distinct belief that we have been able to decrease the thromboembolism incidence on our service. Approximately two years ago the use of alpha tocopherol and calcium was discontinued on the Tulane Service at the Charity Hospital but was continued on the surgical service at the Foundation Hospital. During this same period of time approximately the same number of patients underwent major surgical procedures on the two services but there was a considerable difference in the incidence of fatal emboli. There were 9 fatal pulmonary emboli on the Charity Hospital service during the 6 month period of time and only one fatal pulmonary embolism on the Foundation Hospital service. We, therefore, believe that the combination of alpha tocopherol and calcium exerts an antithrombic activity; and

although it is not as protective as one might want it, it has the decided advantage that it can be used safely without danger of producing hemorrhagic tendency. A recent report by Wilson and Parry substantiates these results. Quoting from their article: "Of the controls, 9 patients had severe deep venous thromboses in the legs, and 2 of these had non-fatal pulmonary emboli; in addition, one patient had a severe superficial thrombosis (not associated with a drip or with varicose veins); 3 others had mild deep thromboses shown by calf tenderness. In the treated group there were no severe deep thromboses and no pulmonary emboli, but 7 patients had mild deep thromboses, and 3 mild superficial thromboses."

The method of administration of alpha tocopherol and calcium which we have used has consisted of the administration of alpha tocopherol, 200 i.u. every 8 hours, by mouth in the form of alpha tocopherol phosphate or, if the patient is unable to take substances by mouth, which so many patients who have recently been operated upon cannot do, they are given 100 mgm. of alpha tocopherol intravenously every 8 hours. In each instance, 10 cc. of 10 per cent calcium gluconate is given intravenously every 24 hours.

SUMMARY

Venous thrombosis continues to be a menace and occurs in about one in every 500 admissions. It is essential to differentiate between two types of venous thrombosis, thrombophlebitis in which the diagnosis is easily made and phlebothrombosis in which the diagnosis is extremely difficult. In the former, the symptoms are maximal and persistent sequelae are likely to occur if adequate therapy is not instituted early but prognosis as regards life is good. In the latter, the symptoms are minimal, if present at all, diagnosis is difficult, but the patients are potential fatalities.

The treatment of thrombophlebitis consists of vasodilatation which quickly relieves the clinical manifestations. The treatment of phlebothrombosis is venous ligation of the cardiac side of the area of thrombosis.

Much can be accomplished prophylactically by avoiding factors which predispose to venous thrombosis, such as circulatory stasis and tissue damage, and by the administration of alpha tocopherol and calcium.

BIBLIOGRAPHY

Ochsner, Alton; DeBakey, Michael E.; DeCamp, Paul T.; and da Rocha, Eudorico: Thrombo-Embolism. An analysis of cases at the Charity Hospital in New Orleans over a 12-year period. Ann. Surg. **134**:405-419; (Sept) 1951.

Ochsner, Alton: Cause and Prevention of Thromboembolism. Postgrad. Med. **10**:394-402; (Nov.) 1951.

Wilson, M. G., and Parry, E. W.: Clinical Trial of Alpha-Tocopherol in the Prophylaxis of Thrombo-Embolism. The Lancet. p. 486; (Mar. 6) 1954.

‹ ‹ ‹ › › ›

Mass hearing tests

A few school nurses have been trained to do mass hearing tests using the pure-tone audiometer. These nurses examine about 20,000 pupils each year and find approximately 4 per cent with sufficient hearing loss to interfere with their educability. At the time of the complete physical examination the medical examiners test hearing by means of the whispered voice. They find less than 1 per cent of the pupils with defective hearing. Otologists tell us there is no satisfactory method of testing hearing acuity except with the audiometer. All pupils found by audiometer to have hearing loss are referred for ear, nose, and throat examinations, either by private physicians or by the school otologist. Hearing loss can be improved in some cases through treatment and in others it can be kept from advancing. *Ruth H. Weaver. Philadelphia Med. April 8, 1955.*

The Practicing Physician's Role in the Control of Poliomyelitis

Leonard M. Schuman, M.D., M.Sc., Assoc. Prof. of Public Health, University of Minnesota

THE recent announcement by Francis of the relatively high efficacy of the Salk vaccine in the prevention of paralytic poliomyelitis has provided both the public and the medical profession with an optimism far exceeding any which has, in the past, greeted the development of a therapeutic or prophylactic agent. We must not, however, permit our optimism to over-rule our objectivity in contemplating the control of poliomyelitis within the next several years. The job of controlling poliomyelitis has just barely begun and we must turn our minds and activities to the practical problems confronting us.

The establishment of the efficacy and apparent safety of the Salk vaccine, as demonstrated by its application in over 400,000 children in 1954, has placed a multifold responsibility upon both the practicing profession and the official health agencies as joint partners in the conquest of this disease. First and foremost of the joint tasks which face us as of this hour is the need to disabuse the public of the apparent misconception that poliomyelitis will not attack the vaccinated individual. It would appear that the emotionalism which has greeted the diagnosis of the disease, its rise in incidence and earlier attempts at its control demands of the current vaccine a perfection not expected of our old "standbyes" such as smallpox vaccine and diphtheria toxoid. Physicians will have to advise their patients and health departments, the public in general, not only that protection will not follow immediately after the first and second inoculations but also that non-paralytic disease may still occur and that 10-30% will still succumb to the paralytic form. As vaccines are improved and their antigenicity kept from deteriorating, these failures will be diminished. On the other hand this incidence of failure must not be permitted to detract from currently developing vaccination programs and discourage parents from their acceptance. The public will have to be reminded that failures occur even in diphtheria, pertussis and smallpox prophylaxis.

The task of inoculating an eventual total of 46 million children and, if necessary, maintaining their immunity for several years to come by annual booster injections,, is a formidable one both in the light of numbers and because of the relatively slow speed with which vaccine can be produced at least at the present time. Physicians for the next few years will be actively engaged in inoculation programs in their offices, in schools and in public clinics as the size of the community and its needs warrant until the vast backlog of susceptibles will have been exhausted and the population at risk narrowed down to new births and susceptible inmigrants.

Poliomyelitis has not yet been controlled and hence there should be no neglect on the part of physicians in maintaining the enviable reporting system which has been established over the years and which has contributed to the wealth of analytic data making prophylactic field trials both possible and practical. The duty to report all cases and to request health department participation in the investigation of them becomes even more urgent with the advent of a vaccine than ever before. Meticulous attention to clinical diagnosis will have to be given and, to the extent that laboratory facilities expand and become more readily available, physicians will have to draw upon such services in order to establish the types of virus encountered and hence contribute to the data on continued efficacy of this or subsequent vaccines. As such facilities are made available the physician will not be satisfied with anything less than a definitive diagnosis despite its presently retrospective character, especially since other viruses may produce central nervous system disease and relatively recent evidence has demonstrated the

---

Presented before the General Assembly, 115th Annual Meeting, Illinois State Medical Society, Chicago, May 18, 1955.

existence of so-called "orphan viruses" producing similar signs. As the disease declines, the tendency not to keep poliomyelitis in mind as a differential diagnosis will grow stronger and until more nearly perfect vaccines are developed the practitioner himself will have to remember that from 10 to 30 per cent of inoculated children may continue to develop poliomyelitis.

Additional uses of carefully kept physicians' and health department records will become necessary for several reasons. Batches of vaccine may present a variability in antigenicity or ability to provoke protection and this variability should be charted in all areas especially in the next several years. Surveys of trends of vaccinal protection will become a joint physician-health department responsibility.

Thus far, our optimism has assumed that etiologic agents producing poliomyelitis will remain confined to the three basic prototypes or their subtypes. Variants of the polio virus may well arise by cellular evolution or mutation producing disease in vaccinated individuals. Unless adequate records of all poliomyelitis immunizations are maintained by physicians and the health department encouraged to make necessary epidemiologic investigations, a hazardous lag in the appraisal of such variants may be encountered. New types of virus may appear on the scene which are not amenable to vaccine protection and these, too, may have to be ascertained quickly for augmentation of current vaccines in order that a recrudescence of incidence may not occur. Our experience with influenza vaccines is an illustration to the point.

There is no information whatsoever at the present time as to the total percentage of the child population which will have to be inoculated to bring about a suppression of poliomyelitis incidence to extremely low residual levels. Such data will have to be gathered on a statewide or even a national basis for adequate interpretation because of the low total attack rate from this disease. Physicians will assist materially in such evaluations by augmenting data available to health departments from school programs with suitable but simple information from their private practices.

In the coming months, with vaccine in short supply, physicians will continue to be morally responsible in "hewing to the line" in providing immunizations for those who by virtue of age or special risk are most susceptible to the disease. Black-markets do arise in materials of short supply and the emotional elements attending the control of poliomyelitis will frequently demand participation on the part of the practitioner in the suppression of such practices.

Surveillance programs, which are usually established by health departments for diseases of low prevalence, should be established currently for poliomyelitis. Were it not for such programs in anticipatory operation in some states as a natural sequel to earlier programs of epidemiologic investigation, the immediate alert to difficulties with the vaccine of one manufacturer would not have been possible. Now and later when poliomyelitis *will* have reached low sporadic levels, the private physician owes to his community the responsibility of maintaining a firm partnership with his health department in surveillance programs for this and similar reasons already mentioned. In summary it may be said that the availability of an apparently efficient, protective tool carries with it serious responsibilities which cannot be dissociated from its use.

‹ ‹ ‹ › › ›

Collateral Cardiac Circulation

Alene Bledsoe, M.D., Marshfield, Wisconsin

THE development of collateral (anastomotic) coronary arterial circulation has been recognized for many years. The process occurs in response to myocardial need of oxygen, because of increased demand or diminished supply or both. Robb[1] and Blumgart[2] have implied that collateral development is simply the enlarging, to functional caliber, of existing vessels rather than proliferation of new vessels.

The fact of coronary anastomosis in varying degrees in some hearts and its absence in others, was reestablished by our recent study utilizing radiopaque injection of the coronary arteries, with x-ray and subsequent dissection[3]. Different colored dyes were added to the injection medium for the right and the left coronary artery, to facilitate dissection confirmation of the x-ray studies. Figure 1 illustrates the degrees of anastomotic development. Comparing these radiographic findings with the pathology and clinical history of each of 81 cases led us to some conclusions regarding the functional significance of coronary collaterals.

Failure to develop collateral circulation in a few needy hearts is not yet well explained. While massive circulatory impairment often arises after extensive sclerosis of the coronary arteries, we found that the anastomotic branches do not share in the inflexibility to any degree prohibitive of their functional dilatation. We observed also that the coronaries were not sclerotic in some hearts failing to develop anastomoses.

In massive occlusion of a heart with a previously unstrained coronary circulation, there often is insufficient time for much collateral development before death occurs. The experimental work of Prinzmetal et al[4] has shown that functionalization of coronary anastomoses *begins* within minutes of coronary arterial occlusion. The length of time required for sufficient anastomotic development in humans to sustain a relatively normal, useful life is not yet clear since so many other factors enter into recovery of the patient. Timing collateral development from the known onset of anginal symptoms, in patients who come to necropsy with myocardial scarring or infarction, is far from accurate; since factors placing anoxic strain on the heart may have been in action long before symptoms appeared.

Blumgart[5] has said that development of collateral circulation from the right coronary artery is difficult. This was borne out in our series, in which right coronary impairment often resulted either in death or in meager supply from the left coronary. In patients whose anastomoses paralleled cardiac hypertrophy without coronary artery disease, the most common underlying causes were cardiac valvular deformity, congenital cardiac defect, and pulmonary disease. These patients usually escaped illness of a coronary hemodynamic nature until such time as the underlying disease or one of its complications brought them to terminus.

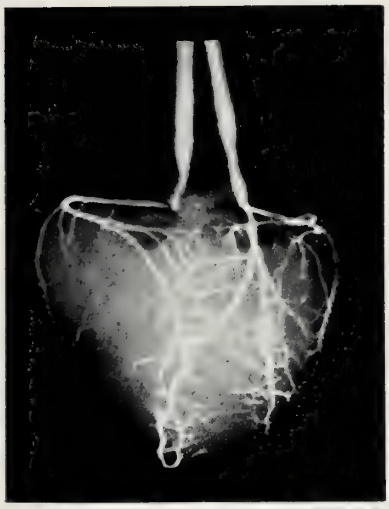
Patients with coronary artery pathology survived longer and tolerated a reasonably active way of life, *if anastomoses were well established.* Likewise, many withstood successive myocardial injuries over several years (one as long as 20 years). The condition of these patients, however, was more precarious than that of persons without coronary disease.

F. L., an 80 year old white man, had suffered a previous coronary episode with myocardial infarction and scarring. For six months occasional attacks of cardiac asthma had occurred but he had been able to maintain a moderately active program. However, with the added strain of inguinal herniorrhaphy (tolerated without immediate difficulty) he came to sudden cyanotic death six days post-operatively. Coronary studies showed a rich anastomotic supply, and an old recanalized occlusion in the left anterior descending artery, with a generally sclerotic coronary tree.

From the laboratories of the Marshfield Clinic and St. Joseph's Hospital, and the Marshfield Clinic Research Foundation, Marshfield, Wisconsin.

This work was supported by a grant from Eli Lilly & Company, Indianapolis, Indiana.

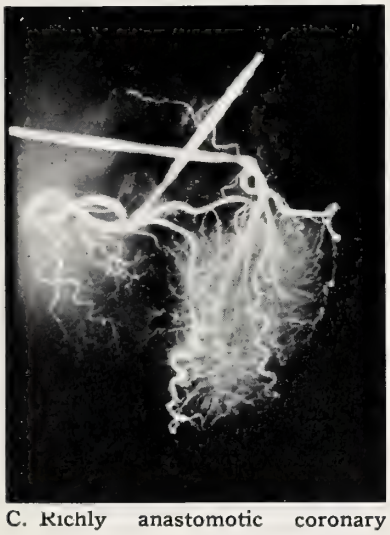
Figure 1



A. Coronary arteries of a normal young person who was accidentally killed.



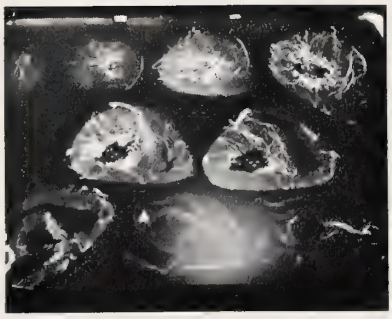
B. Moderately anastomotic coronary arteries of a young adult who died of uremia due to chronic pyelonephritis.



C. Richly anastomotic coronary arteries of a middle-aged person with mild coronary sclerosis and small myocardial scars, who died of carcinoma.



D. Richly anastomotic coronary arteries of an elderly person with severe coronary pathology.



E. Cross sections of the same heart as D, showing the coronary anastomoses concentrated in the area of an extensive old myocardial scar.

F. K., a 74 year old white man, whose coronary arteries were essentially without pathology or anastomoses, had tolerated erratically controlled diabetes for many years and a nutritional status at the cachexia level for one year, during which time exertional dyspnea and mild ankle edema had been noticed. After a hip fracture (with well tolerated surgical correction) he developed bronchopneumonia and acute pyelonephritis, which responded well to antibiotics. Diabetes, however, became uncontrolled, and the patient died when acidosis supervened. At necropsy, no myocardial damage, old or recent was discovered.

These illustrative cases are in accord with the concept of Blumgart[6] that anastomotic circulation can meet ordinary needs but provides no wide margin of safety. The collaterally augmented circulation fortifies the heart somewhat against coronary occlusion; but is less efficient against other constitutional or hemodynamic strains, than a normal coronary circulation without anastomoses.

Much has been hoped for in regard to aiding the development of coronary collaterals, especially in persons with symptoms of ischemic diseases of the heart. It is reasonable to suppose that any coronary vasodilator drug would be of assistance here, especially those with prolonged action maintained over most of the 24 hours of the day. Some clinicians, however, declare that nitroglycerin is the only helpful drug in collateral circulatory development. Graduated anoxia producing strains of the myocardium, just short of the severity necessary to produce damage, has been advocated as an adjunct in the management of coronary circulatory impairment, but is too risky and unpredictable for conscientious use upon humans.

SUMMARY

1. Enlargement of coronary arterial anastomoses to functional caliber occurs in response to myocardial need of oxygen, and requires an undetermined length of time for adequate establishment.

2. Anastomoses, in hearts without coronary pathology or myocardial damage, assist survival and reasonable activity until the underlying disease has reached overwhelming proportions.

3. Patients with coronary disease with anastomoses to a significant degree, are thereby assisted toward withstanding of further myocardial insult, and toward a reasonably active way of life.

4. Even with rich anastomoses, the situation of the person with coronary disease is always precarious, so that he does not withstand other diseases or stresses so well as the person with a normal, nonanastomotic coronary tree.

5. Hopeful conideration is given to future studies on drug aids to coronary collateral functionalization.

BIBLIOGRAPHY

1. Robb, J. S. and Robb, R. C.: The Normal Heart, Am. Ht. J. **23**: 4 (April) 1942.
2. Blumgart, H. L., Schlesinger, M. J. and Davis, D.: Studies on the Relation of the Clinical Manifestations of Angina Pectoris, Coronary Thrombosis, and Myocardial Infarction to the Pathologic Findings, Am. Ht. J. **19**: 1 (Jan.) 1940.
3. Miale, J. B. and Bledsoe, A.: The Pathologic Anatomy of Coronary Heart Disease with Particular Reference to Cardiac Muscle Bundles, Arch. Path. Dec. 1953.
4. Prinzmetal, M., Bergman, H. C., Kruger, H. E. Schwartz, L. L., Simkin, B. and Sobin, S. S.: Studies on the Coronary Circulation. III. Collateral Circulation of Beating Human and Dog Hearts with Coronary Occlusion, Am. Ht. J. **35**: 5 (May) 1948.
5. 6. Blumgart, H. L.: Ibid.

Aneurysm of the Splenic Artery

C. Colangelo, M.D., Chicago

ANEURYSM of the splenic artery is rare and the diagnosis seldom is made without surgical exploration or postmortem examination. Its incidence was reported as .08 per cent in 1,150 autopsies by Muller in 1902[1], and .03 per cent in 3360 autopsies by Cosgrove in 1947[2]. In Alexian Brothers Hospital there have been two aneurysms of the splenic artery in 1,800 autopsies (1926-1953), an incidence of 0.11 per cent. One ruptured and caused death; the other was an incidental postmortem finding. To date, 216 cases have been recorded, including the case reported in this paper. The last 12 have been added since Owens and Coffey reviewed the literature up to 1950 and reported six additional cases[5].

The splenic artery is an infrequent site for aneurysm formation, being preceded by the thoracic aorta, abdominal aorta, popliteal, femoral, carotid, subclavian, and innominate arteries in that order. According to Von Ronnen, aneurysm of the splenic artery is four times as common as aneurysm of the renal artery[3].

The most common cause of aneurysm of the splenic artery is arteriosclerosis[4]. The other causes, in the order of frequency, are: mycotic embolus due to endocarditis, congenital defect in the wall of the artery, portal hypertension, and pregnancy [2,4,5]. The role of pregnancy in the formation and rupture of splenic artery aneurysm remains unsettled, but the relatively high incidence of rupture of a splenic artery aneurysm in pregnancy is well documented[2,6,7,8,9,10].

SYMPTOMS

Any review of this condition reveals the wide variety of symptoms it produces and the difficulty in establishing diagnosis.[2,5] Symptoms arise from three main sources: Stretching or rupture of the aneurysm without significant bleeding; rupture with serious bleeding; and interference with the circulation of blood through the spleen. Symptoms also may be caused by pressure of the aneurysm on neighboring organs or by bleeding into nearby tissues. If none of these factors is operating, there will be no symptoms. Symptoms and their order of frequency, according to Owens and Coffey, are: Upper abdominal pain usually in the epigastrium or left upper quadrant 70 per cent, nausea and vomiting 30 per cent, hematemesis 18 per cent, constipation and diarrhea 17 per cent, indigestion 14 per cent, weakness 11 per cent, melena 11 per cent, dyspnea and vertigo 8 per cent, weight loss and epistaxis each 5 per cent. Of the cases reviewed, 29 per cent reported no abdominal pain[5].

Symptoms often are minimal or absent: rupture of the aneurysm with shock and an acute abdominal emergency often is the first evidence of disease. With rupture, the course of the disease may be rapid, death occurring several hours after the onset of symptoms due to massive hemorrhage[6,7,8,9,10]. On the other hand, if the hemorrhage is not immediately fatal, there is temporary improvement with a relatively asymptomatic interval of days to weeks which is terminated by a second episode of tearing of the aneurysm, resulting in death.

PHYSICAL FINDINGS

Pathognomonic findings are an expansile tumor or a bruit, but these are infrequent. In a review of 131 cases by Owens and Coffey, an expansile tumor was recorded only 10 times, and a bruit was heard in 12. Other physical findings that may occur are: Splenomegaly (which is the most common), shock, abdominal tenderness, a left-sided abdominal mass, and abdominal distention, the last four being fairly common. Abdominal rigidity and a fluid wave are less common findings.

Laboratory studies are not diagnostic. They may reveal anemia and leukocytosis. Stool examination may indicate pancreatic insufficiency. Elevation of the serum amylase was noted in one case by Owens and Coffey[5]. Palmer men-

tioned obtaining a normal serum amylase on several occasions in the postoperative period following resection of a splenic artery aneurysm[11]. No other references to serum amylase levels in this condition were noted in the literature up to the present time (October 1954).

DIAGNOSIS

Diagnosis is extremely difficult since many conditions may be confused with rupture of a splenic artery aneurysm including: perforated peptic ulcer, acute pancreatitis, mesenteric thrombosis, coronary occlusion, acute intestinal obstruction, ruptured spleen, ruptured tubal pregnancy, abruptio placenta, placenta previa, ruptured uterus, and dissecting aneurysm of the abdominal aorta.

When there is enlargement of the spleen or an upper abdominal mass, the condition must be differentiated from Banti's disease, splenic cyst or tumor, pancreatic cyst or tumor, blood dyscrasia, and mesenteric cyst. The finding of a big spleen or an abdominal mass is fortunate since it often leads to surgery which both reveals the pathology and removes it [11,5,12,13].

Roentgen findings are of great diagnostic value but are not commonly present. Diagnostic roentgen findings consist of a tubular or saccular calcification in the splenic artery area. Suggestive changes include a mass in the left upper quadrant which may pulsate, displacement or extrinsic pressure on the stomach and splenic flexure of the colon, elevation of the diaphragm, and displacement of the left kidney. In two reported cases aortography was used to demonstrate the aneurysm. In both, the plain films also showed it [15,5].

Surgical exploration is the most useful and productive diagnostic procedure available. It must be used whenever there is an acute abdomen with or without evidence of internal bleeding unless strongly contraindicated.

To demonstrate the difficulty of diagnosis in this condition, the following figures are cited: of 216 cases recorded to date, only 21, or 10 per cent, were diagnosed short of surgical exploration. Seven of this total have been added in the last three years [3,14,15,16]. In all seven, diagnosis was made by x-ray evidence of a saccular or tubular calcification in the splenic artery area.

In summary, the diagnosis is suggested by the presence of a left upper quadrant mass or splenomegaly. Suspicion should increase when there is shock and the picture of an acute abdomen. X-ray evidence of calcification in the aneurysm is diagnostic but it is a relatively infrequent finding.

TREATMENT

Treatment is surgical excision or ligation of the aneurysm. At times, splenectomy may also be necessary.

Without surgery, death almost invariably follows rupture of a splenic artery aneurysm, but with surgery eight patients were saved in 23 cases, a survival rate of 34 per cent [3,5,11,12,17,18].

Without rupture, the survival rate is much higher but because there is the danger of rupture, prompt surgery is advised whenever aneurysm of the splenic artery is found, even if asymptomatic. Von Ronnen, however, advises observation provided the aneurysm is small, asymptomatic, and not in a pregnant woman or a patient with hypertension[3].

To date surgery has been done in 71 cases and of these, 38 survived. Survival rates are continuing to improve as evidenced by a rate of 100 percent in the last 11 of the 71 operative cases [3,5,11,12,13,14,15,16,17]. This excellent record is due not only to better surgical and medical care but also to the fact that eight of these 11 cases had surgery before the aneurysm reptured.

A ruptured splenic artery aneurysm may resemble a disease in which surgery is contraindicated, such as acute pancreatitis. In such instances the prognosis will remain poor and the mortality high. The following case report exemplifies these remarks.

CASE REPORT

A 68 year old white male was admitted to Alexian Brothers Hospital with a four hour history of severe, constant, nonradiating epigastric pain. At the onset there had been some vomiting, weakness, and a syncope of short duration. Vomiting occurred again but was never prominent or bloody. The patient's health prior to this illness had always been good.

Entrance examination revealed an anxious, acutely ill patient with a blood pressure of 140/80 and a normal pulse, temperature, and respiration. The extremities were cyanotic and cold.

On the following day the patient fainted and went into shock with a drop in blood pressure to 80/60 and a pulse rate elevation to 165. In the following 24 hours, the abdomen became diffusely tender and

mildly distended and a fluid wave was palpable. The serum amylase on the third day of the illness was 2000 units (normal 150-350). Other laboratory data were: R.B.C. 4,200,000; W.B.C. 18,400 with 83 per cent segmented polymorphonuclear forms; N.P.N. 34; glucose 123; creatinine 1.5. The urine contained hyaline and granular casts as well as a trace of albumin and sugar. A chest film was normal and a bedside film of the abdomen showed a diffuse hazy opacity interpreted as fluid (ascites). No calcification was seen; no mass was made out.

In view of his poor physical condition and since the provisional diagnosis was acute pancreatitis, surgery was considered inadvisable and symptomatic treatment was instituted including Levine suction, plasma, whole blood, and intravenous fluids. The patient responded well and within a week was ambulatory and eating with a good appetite. The serum amylase dropped to 660 units and the serum lipase was .04 (normal 0.0 to 0.3). He died suddenly early in the 14th day of his illness without any premonitory symptoms.

Postmortem was done by Doctor James P. Simonds and the pertinent findings are quoted directly, or given in essence by his permission:

The peritoneum contained 3 liters of fluid and clotted blood.

The tail of the pancreas was included in and surrounded by a mass of blood in the retroperitoneal tissue measuring 12x9x7 cm. "The splenic artery was dissected out and was opened; at a place 5 cm. from the hilus of the spleen there was a saccular dilatation of the vessel with an opening in its wall 9 mm. in diameter and continuous with a sac 2.5 cm. in diameter that was imbedded in the mass of hemorrhage described above. It was not possible to determine the exact size of the original sac because its wall was lost in the mass. In the tail of the pancreas there were bands of hemorrhage between the groups of lobules of pancreatic tissue. No fat necrosis was found."

The spleen contained a 2.4 x 1.5 cm. infarct but it was not enlarged.

SUMMARY

The recent literature on aneurysm of the splenic artery has been reviewed and a case reported in which rupture of the aneurysm was accompanied by marked elevation of the serum amylase presumably due to intra and peripancreatic hemorrhage. The clinical diagnosis was acute pancreatitis. The true diagnosis was revealed by postmortem.

Diagnosis of splenic artery aneurysm with rupture is difficult and prognosis consequently is poor. If recognized in time, surgery is able to save about 50 per cent of the patients. To this end, more frequent exploratory laparotomy is urged in acute abdominal conditions, particularly where intra-abdominal hemorrhage is suspected.

BIBLIOGRAPHY

1. Muller, E., Zur Stastik der Aneurysmen, G. Fisher, Jena, 1902.
2. Cosgrove, G., Jr. Watts, J., and Kaump, D., Spontaneous Rupture of Splenic Arterial Aneurysms; Report of 3 Cases, Am. J. Clin. Path. **17**:372-382, May 1947.
3. Von Ronnen, J., Roentgen Diagnosis of Calcified Aneurysm of Splenic and Renal Arteries, Acta Radiol. **39**:385-400, April 1953.
4. Anderson, W., Textbook of Pathology, Page 536. C. V. Mosby Company, St. Louis, 1953.
5. Owens, J., and Coffey, R., Aneurysm of the Splenic Artery including a report of 6 Additional Cases, Internat. Abstr. Surg. of Surg, Gynec. & Obst. **97**:313-335, Oct. 1953.
6. Specken, J., and deBruyn, N., Rupture of Aneurysm of Splenic Artery as Complication of Labor, Nederl. Tijdschr. Geneesk, **94**:249-251, Jan. 28, 1950.
7. de Vink, L., and Van der Linde, H., Aneurysm of Splenic Artery During Second Half of Pregnancy; case, Nederl. tijdschr. geneesk. **94**:15-21, Jan. 7, 1950.
8. Tennent, R. A., and Starritt, A., Case of Rupture of Aneurysm of Splenic Artery during Pregnancy, Glasgow, M.J. **31**:465-466, Dec. 1950.
9. Chalmers, J. A., Rupture of Splenic Arterial Aneurysm as Fatal Complication of Pregnancy, Brit. J., Surg. **37**: 86-90, July 1949.
10. Tomsykoski, A., Stevens, R., Izzo, P., and Rodriquez, C., Aneurysm of the Splenic Artery in Pregnancy, Am. J. Obst. & Gynec. **66**:1264-1270, Nov. 1953.
11. Palmer, T. H., Aneurysms of Splenic Artery, New England J. Med. **253**:989-993, Dec. 21, 1950.
12. Milone, S., Aneurysm of the Splenic Artery, Arch. Ital. di Chir. **75**:427-440, 1952 No. 6.
13. Ghabrial, F., Aneurysm of Splenic Artery with Report of Case Complicating Egyptian Splenomegaly, J. Roy. Egyptian, M.A., **33**:411-423, 1950.
14. Querna, M., Aneurysm of the Splenic Artery, N.W. Med. **52**:445, July 1953.
15. Berger, J. S., Forsee, J. Y., and Furst, J. N., Splenic Arterial Aneurysm, Ann. Surg. **137**:108-110, Jan. 1953.
16. Crossman, L., Haley, M., and Carroll, R., Splenic Artery Aneurysm, Med. Rec. and Ann. **48**:889, May 1954.
17. Wood, W. S., and Hall, B., Rupture of Spleen in Subacute Bacterial Endocarditis, Arch. Int. Med. **93**:633-640, April, 1954.
18. Dobson, L., Morse, D., and Covert, J., Aneurysm of Splenic Artery, Stanford M. Bull **5**:39-42, Feb. 1947.

Uncommon Sites Of HERPES ZOSTER

F. Garm Norbury, A.M., M.D., F.A.C.P., Jacksonville

HERPES zoster or shingles receives but a page or two in most text books of neurology. Physicians seeing patients undergoing severe postherpetic neuralgia realize that suffering may be intense. While the disease is usually described as one of the minor infections of the nervous system it may well be major as regards complications or pain for certain patients.

The names of the illness are derived from the more common location on the trunk, "*Zoster* (Greek) and *Zona* (Latin) signify a girdle as does the word *cingulum* from which the common term shingles is derived."[1] The lesions follow skin distribution of segmental type, i.e. the primitive dermatomes over trunk and extremities. On portions of the head they follow representations of skin distribution of the two sensory ganglia outside the brain, i.e. Gasserian and geniculate, for the fifth and seventh cranial nerves respectively. By reason of the important structures included in the sensory distribution of the fifth nerve, involvement there is more serious. This applies particularly, of course, to the first or ophthalmic division with possible corneal localization of the herpetic lesions and later scarring and visual impairment.

Every physician sees patients with herpes zoster. The segmental character of the preliminary itching or pain followed by the appearance of the characteristic vesicles make the diagnosis. Often patients make the diagnosis themselves when the blebs appear on the trunk. This is the most common location, with segments from T2 to L3 being most frequently involved.

Other segments may be involved. That is the occasion for this paper. We are all accustomed to thinking of peripheral nerve distribution over the extremities. We speak of musculospiral, median, ulnar in the arm; of anterior crural, sciatic, the popliteals and so forth in the leg. These nerves arising from the brachial, lumbar or sacral plexus have sensory and motor fibers from different segments. Peripheral nerve or plexus disorders therefore include more than one segment. That is the difference between the pain sensations for them and the segmental pain of herpes zoster. When it is remembered that the arms and legs are extensions from the primitive body tube and the nerve fibers are carried out through these extensions the explanation on the basis of anatomy and neuropathology is evident.

The potentially most serious of the uncommon herpes zoster conditions is involvement of the ophthalmic branch of the fifth or trigenminal nerve. When the skin lesions are discrete there is less likelihood of invasion of the cornea. When they are numerous and tend to coalesce the numerical frequency is of itself apt to include the cornea. At times the skin irritation may be so great as to make one think of erysipelas. The limitation of the vesicles to the distribution of the ophthalmic division and their character helps in differential diagnosis. The second and third divisions of the trigeminal nerve less frequently have herpetic difficulty.

The sensory representation of the seventh nerve is on the posterior surface of the ear, in the cleft, and on the tympanic membrane. Herpetic lesions in this area are extremely uncommon. The appearance of such lesions in two patients with facial paralysis some years ago has made me look for them in every Bell's palsy situation since then. Only one has been seen in that interval but not since the Kodachrome series was started.

The arm and hand areas rarely present zoster lesions. One instance of C5 distribution was seen following injection of typhoid vaccine. C8 distribution is of interest as representing an isolated area of one portion of the ulnar nerve. D2 representation on the inner surface of the upper arm has been observed several times. If

Presented before the Section in Medicine, Illinois State Medical Society, May 19, 1955

one did not think of segmental anatomy it would be difficult to reconcile the arm and chest location of the vesicles.

Distribution on the lower part of the trunk leads to some locations that at first appear odd also. However, when segmental areas are considered and one remembers that in humans as in animals the legs are in front of the tail this is clarified. That explains why there is a difference in the localization of the herpes vesicles in the genital region as compared with those in the anal area. I am indebted to Dr. McCuskey of Peoria for the fine slides that show an L1 lesion as compared with an S3 area.

The anatomical localizations brought by Head[2] many years ago have remained as decisive factors over the years. Most of our knowledge of sensory distribution in relation to anatomy stems from those studies. The causative factors of herpes zoster as a virus infection involving sensory ganglia came later. One of the most interesting features of this is the association with varicella or chicken pox. Stokes[3] in fact in his section of Rivers' book heads the chapter "Varicella-Herpes Zoster Group" and collects the literature associating these two conditions.

A patient on the same floor with the one mentioned as having herpes zoster of the ophthalmic division of the trigeminal nerve developed chicken pox. This chicken pox patient, a long standing schizophrenic, had not been off the floor during the intervening time; neither had any of the nurses shown any signs of this nor had there been any case of chicken pox in the families of those who resided off the premises. The epidemiologic evidence appeared rather conclusive.

As regards treatment the more frequent references in recent years have been along the lines of what might be called nonspecific remedies. Whereas emphasis was laid on intravenous sodium iodide in the paper[4] presented twenty years ago before this Society less use of this has been made since that time. That perhaps is an indication of changing styles in therapy. The introduction of B_{12} for various neuropathies, both central and peripheral, has led to its use in large doses of one thousand micrograms in the acute phase plus the generally accepted use of members of the salicylate group for analgesic effect. Local soothing applications of zinc oxide or calamine preparations help in all areas. Sulfacetamide and hydrocortisone ointment appear to help the conjunctival and corneal irritation when the ophthalmic division of the trigeminal nerve is the involved area, plus of course, conjunctival hygiene.

For the postherpetic neuralgia, whether it be in the more commonly located areas on the trunk or those referred to in this discussion, the nonspecific protein preparation, Protamide,® has appeared to give relief. Early impression of its helpfulness in lightning pains of tabes led to its application in this other condition.

In summary then it may be said that while herpes zoster or shingles is generally thought of as involving the human trunk it may occur over any area subserved by a primitive dermatome with sensory representation. A recollection of the fundamental neuroanatomy helps in diagnosis of the condition when some uncommon neuralgic pain or skin irritation appears. This is especially important when one of the extra cerebral sensory ganglia, particularly the Gasserian ganglion, is involved. The association with the virus infection of varicella or chicken pox is mentioned. Nonspecific therapy appears to alleviate some of the symptoms and signs of the disorder, since by the time these appear no specific therapy that is of definite value has thus far been developed. Nonspecific therapy also helps postherpetic neuralgia.

The Norbury Sanatorium.

REFERENCES

1 Fox, Howard: Skin Diseases, Clinical Pediatrics, **16**:87, D. Appleton and Co., New York, 1930.

2 Head, H. and Campbell, A. W.: The Pathology of Herpes Zoster and its Bearing on Sensory Localization, Brain, **23**:353, 1900.

3 Stokes, Joseph Jr.: Viral and Rickettsial Infections of Man, Thomas M. Rivers, Editor, p. 395, J. B. Lippincott and Co., Philadelphia, 1950.

4 Norbury, F. G.: Herpes Zoster, Ill. Med. Jour. **68**:134 (Aug.) 1935.

Management of the Pyodermas

Hilliard M. Shair, M.D., Quincy

THE common skin diseases due to pus-forming bacteria can be as well treated by the family physician as by the dermatologist. The specialist's function is to evaluate the efficiency of different treatment programs in these diseases and to report his findings to the general physician. This paper, therefore, is a brief and dogmatic report of the best treatment that I know for several common pyodermas. The specific conditions which will be discussed are impetigo contagiosa, ecthyma, furunculosis, erysipelas and infection of the ear canals.

Since we are dealing with fairly simple and usually easily recognized entities, we shall not discuss diagnosis.

IMPETIGO CONTAGIOSA

Impetigo contagiosa is a superficial infection of the skin which should respond to treatment in five to seven days. The older preparations of ammoniated mercury and gentian violet have been superseded by newer remedies. However, one old remedy, soap and water, is still a very important part of the management. In fact, removing the crusts and washing the infected areas, no less than five times daily, is the first step in treatment. Though plain soap is very good, a hexachloraphene containing soap or detergent (such as pHisoHex (R)) may be used with advantage. After removing the crusts and washing the infected areas, the lesions are then rubbed with a suitable antibiotic ointment. The now older sulfonamide and penicillin ointments, though they are quite exective, are not used because too often they result in sensitization of the skin. Aureomycin ointment, terramycin ointment, erythromycin ointment are all excellent. Lately, I have preferred to use the polymyxin-bacitracin or the neomycin-bacitracin mixtures for two reasons: 1) they do not stain and 2) they represent good therapeutic materials which are not likely to be used internally.

Where there is marked oozing from the lesions of impetigo, it is necessary to use an antiseptic drying shake lotion twice daily in addition. A simple example of such a lotion is calamine lotion to which 3% resorcinol has been added. The drying lotion is applied twice daily and the antibiotic ointment three times daily.

Is it necessary to use penicillin injections in so simple a disease as impetigo contagiosa? The answer is "Yes, at times it is necessary and advisable." Intra-muscular procaine penicillin should be used where there is extensive involvement of the skin with impetigo especially when, after a few days of local therapy, there has been no improvement. Here, as in other infections, the internal use of penicillin will shorten the morbidity, reduce the chances of spread to others and will prevent complications. Extensive infection of the skin, can be followed in three or four weeks by nephritis. Though this is an uncommon complication, it is not so rare as to be outweighed by the dangers of penicillin or other antibiotic therapy.

ECTHYMA

Ecthyma is a disease which affects the skin more deeply than impetigo but not as deeply as furunculosis. Ecthyma refers to the small, fairly superficial pyogenic ulcers of the skin which are frequently secondary to trauma, scratching or bites. It is most troublesome on the legs, where healing may be long delayed. The treatment is the same as for impetigo. This means washing with soap and water and an antibiotic ointment rubbed in several times daily. Where healing is long delayed, particularly on the legs, internal penicillin is needed.

FOLLICULITIS

Folliculitis refers to pustular infections of the hair follicles. These infections can occur anywhere on the skin. However, the problem cases we see are mostly folliculitis of the beard, the scalp or the thighs. A discussion of folliculitis of the beard always brings up the question of sycosis vulgaris — the feared "barber's itch."

Presented before the Section on Dermatology, 114th annual meeting, Illinois State Medical Society, Chicago, May 19, 1954.

True barber's itch seems almost extinct. Probably one reason for the disappearance of severe chronic infection of the beard has been the improved effectiveness of treatment of acute and chronic folliculitis.

In outlining the management of folliculitis of the beard to the patient, it is important to give careful instructions in regard to shaving. The preferred antibiotic ointment should be rubbed thoroughly into the beard before preparations for shaving are begun. Plenty of time must be given to the shaving procedure itself. At least five minutes should be spent repeatedly soaping, washing and lathering the face. The beard must be kept wet throughout the shave. A clean razor and a new blade must be provided for each shave. After shaving has been completed, the face is washed again, rinsed thoroughly, dried and finally the antibiotic ointment rubbed in again. The excess ointment is then wiped off. The ointment should again be rubbed well into the beard at bedtime. During the day, the affected areas should be repeatedly dabbed with an astringent antiseptic solution. The solution I prefer is diluted Dalibour water. The formula for the diluted solution is copper sulfate 0.3, zinc sulfate 1.0, water to make 120 cc.

In managing folliculitis of the scalp, the antibiotic ointment should be rubbed in at least every night and shampooed out in the morning. Again, hexachloraphene containing detergent can be used as a shampoo. Once or twice daily, an antiseptic and anti-seborrheic scalp lotion should be used and rubbed in to the scalp. Such a preparation is resorcinol monoacetate 4.5, salicylic acid 4.5, mercury bichloride 0.4, glycerin 6.0, diluted isopropyl alcohol to make 240.0.

Folliculitis which is widespread over the thighs or over other hairy areas of the body is often quite difficult to control. Cleanliness and the avoidance of oil and grease contact are important. A daily bath containing potassium permanganate in a dilution of about 1-50,000 should be used. This means adding 2.0 to 4.0 Gm. (grs. 30 to 60) of $KMnO_4$ to the bath water. This bath may have to be stopped if the skin gets too dry or becomes eczematized. During the day, an antiseptic solution such as 3% resorcinol in diluted isopropyl alcohol is applied two or three times to the affected areas. At night, either an antibiotic or quinoline containing ointment or cream is rubbed in. Vioform Cream® is an example of the latter type. Cleanliness of underclothing and of clothing which rubs against the skin is very important in the management of folliculitis. It is important to continue the treatment for a long periond of time, even beyond the time of clinical cure.

FURUNCULOSIS

The exact treatment of furuncles depends in great part on their number, location, severity and whether or not there is the problem of recurrent furunculosis. One isolated small boil is not much of a therapeutic problem. It can be treated with hot wet dressings and an antibiotic ointment. The ointment is not for the boil itself but for the protection of the nearby skin against the staphylococci. The injection of an antibiotic directly into the furuncle often helps shorten the course of the disease. I use 0.5 to 1.0 cc. of a bacitracin solution mixture. This mixture is prepared by adding 20cc. of 1% procaine hydrochloride solution to a vial containing 10,000 units of bacitracin for topical use. The injection is sometimes repeated in 48 hours.

If the furuncle is severe, especially when located on the upper face or deeply in the buttock, or if the furuncle is accompanied by considerable pain, swelling or lymphadenitis, penicillin is given daily by intramuscular injection for two or three days. The first dose is usually 800,000 units of a mixture of slow and rapid acting penicillins. Succeeding doses are 600,000 units of procaine penicillin. In addition, rest, immobilization of the affected area, hot wet packs and topical antibiotic ointments are prescribed.

The first step in the treatment of recurrent furunculosis is to study the patient, his occupation, personal habits and his health status. Particular attention is given to the possibility of diabetes mellitus. An attempt is made to decrease the bacterial population of the cutaneous surface. Attention is given to cleanliness. Permanganate baths are prescribed as in folliculitis, and hexachloraphene containing soaps may be used. Relatively small doses of sulfonamides or antibiotics by mouth over a period of weeks or months may be of value. I prescribe 2.0 Gm. daily of triple sulfonamides such as Terfonyl or Sulfose. Immunization with mixed staphylococcus bacterial antigen and toxoid is worth trying.

A carbuncle is treated in the same way as a

severe furuncle. Both penicillin therapy and x-ray therapy are used.

In fact, in severe furuncles x-ray therapy has seemed valuable when administered early. X-ray treatment, of course, should be given by a specialist. What about surgical excision of boils and carbuncles to evacuate the pus? In my own experience, it has not been necessary nor has it seemed advantageous to incise these lesions.

ERYSIPELAS

Erysipelas is included in this discussion because of its bacterial origin rather than because of the formation of pus in the lesions. This is now a quite uncommon disease. Some of the cases which have been referred to me as erysipelas have been instead severe contact dermatitis. However, typical erysipelas still exists. In this disease, I use large dosages of penicillin by injection plus sulfonamides by mouth. 800,000 units of a mixture of slow and rapid penicillins are injected the first day. Then, 600,000 units of procaine penicillin is given on subsequent days until both fever and cutaneous inflammation have subsided. At the same time, the patient takes 1 gram of triple sulfonamides four times daily. X-ray therapy and ultra-violet light treatment are no longer needed in erysipelas.

EXTERNAL EAR CANAL INFECTION*

Otitis externa is included in this discussion because of its frequency. This disease is still too often called fungus infection of the ear. In my experience, it is most often a seborrheic dermatitis in which secondary to scratching, a pyogenic infection has occurred. For this infection Aerosporin Otic® drops have been effective in more cases than any other single preparation. Two drops are instilled into the canal four to six times daily for a few days and then twice daily when improvement occurs. Occasionally in otitis externa, it is necessary to use intramuscular penicillin. The patients requiring penicillin have severe pain and often moderate fever either from a small furuncle in the canal or from lymphadenitis.

For the diagnosis and treatment of less common pyodermas,† the reader is referred to the most recent editions of textbooks of dermatology.

SUMMARY

The pyodermas are amenable to speedy and curative results with modern medications. The problem of management resolves itself to answering two questions. These questions are 1) what is the best and simplest local therapy and 2) is internal medication needed? To borrow a phrase from the musical world, two themes recur repeatedly in answering these questions. In the mild pyodermas, prescribe cleanliness, frequent washing with soap and water and antibiotic ointment. In the severe cases, add intramuscular penicillin and oral sulfonamides.

DISCUSSION

Jerome M. Greenhouse, M.D., East St. Louis.—I wholeheartedly agree with Dr. Shair's general approach, particularly in the use of antibiotic ointments. As he has so ably shown, antibiotics have largely superseded the older treatment of the pyodermas. However, as time goes on, some of the organisms causing these pyodermas may become resistant and one may have to revert to true and tried remedies of the past. The underlying principles do remain the same, as Dr. Shair points out. It can not be too strongly stressed, for example, that one must remove the crusts in all the pyodermas before any medication is applied. In addition to the agents mentioned by Dr. Shair that are used for this purpose, I find that hot boric acid soaks are very effective, especially if they are used frequently as they serve a two-fold purpose; namely, not only the removal of the crusts and scabs, but as an antiseptic and anti-inflammatory agent. (A teaspoon of boric acid powder is used to a pint of hot water.) (alum.

Intramuscular penicillin may be used in complicated extensive cases, particularly in children; one should always, however, bear in mind that a latent fungus infection may be activated and cause an extensive id reaction as well as an exacebration of the local fungus infection itself. I find that a schüttle lotion with 3% Xeroform or vioform and 5% boric acid added to it makes a very effective astringent antiseptic lotion for the treatment of widespread folliculitis. Quinolar ointment (Squibb) is very effective also in the treatment of folliculitis. I advise my patients with folliculitis of the beard to use an electric shaver instead of a safety or straight razor. A mixture of aluminum acetate and boric acid powder (teaspoon to a pint of hot water) used before and after shaving, will prevent spread of the infection.

As regards recurrent furuncles, among other things, foci of infection should be looked for, particularly in the tonsils, teeth, sinuses, etc.

Since preparation of this paper, the superiority of combined hydrocortisone-antibiotic lotions and ointments for external otitis has been demonstrated.

†Impetigo furfuracea, impetigo Bockhart, the acute and chronic paronychias, sub-epidermal whitlow, sycosis vulgaris, folliculitis cheloidalis, impetiginized eczema, infectious eczematoid dermatitis, erythroderma of the newborn, pyoderma gangrenosa, dissecting pyoderma of the scalp, diphtheria of the skin, hidradenitis suppurativa, etc.

Gastro-Intestinal Allergy

J. B. Seagle, M.D., Urbana

THE term gastro-intestinal allergy refers to an allergic reaction involving an organ of the gastro-intestinal tract. Gastro-intestinal allergy most commonly occurs as the result of ingested foods, although it uncommonly results from other types of allergens such as medicines. The term gastro-intestinal allergy should be differentiated from food allergy, which refers to an allergic reaction caused by a food, irregardless of what organ of the body manifests the reaction.

Acute or chronic diarrhea of allergic origin is frequently associated with other allergic gastro-intestinal symptoms. The recognition of these is often an essential aid in the diagnosis and treatment of allergic diarrhea. Therefore, some of the other more important gastro-intestinal symptoms which may precede or accompany allergic diarrhea will be mentioned. Brief emphasis will be placed on the prevention, diagnosis, and treatment of diarrhea due to gastro-intestinal allergy.

The signs and symptoms which have been thought to be suggestive of or attributable to gastro-intestinal allergy in infants and children are legion and frequently so vague that evaluation of the symptoms is difficult. Among these symptoms and conditions are: excessive crying, colic, spitting up, vomiting, constipation, loose stools or diarrhea, and pylorospasm. It will be obvious to any physician who takes care of infants and children that these symptoms and conditions are not in most cases due to gastro-intestinal allergy. Since the diagnosis of gastro-intestinal allergy is frequently extremely difficult to prove, caution must be exercised to prevent the erroneous labeling of many unexplained intestinal symptoms and conditions as due to allergy.

Infantile colic is often the first presenting symptom in infancy which suggests allergy. This occurs initially in the first weeks of life when the gastro-intestinal tract is being exposed to various foreign proteins, such as those in cow's milk and mother's milk. Many cases of infantile colic undoubtedly do not have an allergic origin, but in some cases allergy, especially to cow's milk, must be blamed.

Older children with recurrent attacks of mild abdominal pain are frequently seen by the pediatrician. Though it is recognized that gastro-intestinal allergy may produce abdominal pain, with or without other gastro-intestinal symptoms such as nausea, vomiting, or diarrhea, this diagnosis should be considered only when all of the other more common causes of abdminal pain have been excluded. It is surprising how little has been written in pediatric texts on the subject of allergic vomiting and diarrhea. Hypersensitivity to cow's milk is sometimes observed very early in life and may vary from mild colic or spitting up to severe vomiting, diarrhea, and even death.[1] Clein reported in 1951 that in a study of one hundred and forty infants with cow's milk allergy fifty-four infants (39 per cent) demonstrated regurgitation in some form.[1] Glaser[2] states that there appears to be little doubt that pylorospasm may be due to food allergy. There have been well documented cases presented in the literature to substantiate this observation. Allergy to food will occasionally produce recurrent vomiting but is not generally accepted to be the cause of so-called cyclic vomiting. Although both hypertrophic pyloric stenosis and coeliac disease have been attributed to gastro-intestinal allergy, most physicians do not accept these views.

In an excellent review of diarrhea of allergic origin, Rothmann[3] in 1953 divided these cases into two clinical groups: (1) severe diarrhea during the neonatal period with rapid loss of fluids and electrolytes and impending death, and (2) chronic diarrhea during the second year of life simulating coeliac disease. Mild cases of diarrhea occur in both groups and occur with

---

From the Department of Pediatrics, Carle Memorial Hospital and Carle Hospital Clinic, Urbana, Illinois.

Presented before the Section on Pediatrics, 114th annual meeting Illinois State Medical Society, May 19, 1954.

greater frequency than the severe cases. These infants may have frequent watery, yellow or green stools. Mucus is frequently present in large amounts, often being the chief cause of concern to the mother. Gross blood has been reported in the stools of infants and children with allergic diarrhea, particularly in those children with allergy to cow's milk. Diarrhea may or may not be associated with colic, vomting, and low-grade fever.[1, 4] Symptoms in most cases develop during the early months of life but may appear at any age. Severe instances of explosive diarrhea of this type in infants are probably quite rare. Some infants have a limited tolerance to cow's milk manifested by recurrent bouts of mild diarrhea. Many of these infants may have satisfactory weight gains and may not require treatment. These infants are frequently subjected to numerous changes of various proprietary milk preparations without success. Often the use of an acidofied, high protein milk with a relatively low carbohydrate and fat content will help these infants who actually have a functional lowering of digestive powers rather than allergy to milk.

The second group in Rothmann's classification of diarrheas of allergic origin comprised infants in the second year of life with chronic diarrhea. These infants and children have been described in the past as having "mucus disease", "mild coeliac disease", "intestinal catarrh", various types of steatorrhea, and chronic intestinal indigestion. The clinical picture presented by these patients has many features in common with true coeliac disease and in general simulates this condition. The frequency of the number of stools forms the initial complaint. The stools are loose, offensive, and often coated with mucus. There may be loss of weight or poor weight gain, enlargement of the abdomen, and flabbiness of the musculature. These infants may show an excess of mucoid nasal discharge, and there often is enlargement of the adenoids and redness of the tonsils. In some mild cases the physical examination will be entirely negative. Often a history of food intolerance during the early months of life is obtained. This condition may be associated with various evidences of vitamin deficiencies. Rickets may develop in prolonged cases, and evidences of deficiencies of the vitamin B complex, vitamin K, and folic acid may further complicate the picture when antibiotics have been used for prolonged periods.

PREVENTION

As is the case with many diseases, there is considerable difference of opinion as to the incidence of gastro-intestinal allergy, particularly allergy to milk. Loveless[5] has reported that questionnaires sent to 191 pediatricians and allergists practicing on the east coast revealed that milk allergy (all forms) was noted in about 1.5 per cent of their patients. This is in contrast to the opinions of some other workers who have thought the incidence of milk allergy to be five to ten times higher than this figure. Those who have advocated the higher figures, however, have included atypical symptoms which most physicians do not accept as manifestations of allergy.

The pediatrician who sees his patients at regular intervals from birth and throughout infancy is in an advantageous position to practice preventive medicine. This should be done not only in such fields as contagious diseases and safety but also for the infant who is potentially allergic by reason of heredity. There would appear to be insufficient evidence available to warrant restriction of the maternal diet throughout pregnancy in families with highly allergic individuals, although this plan has been suggested by some allergists. However, the diet of the nursing mother may be modified slightly by the avoidance of both unboiled milk and an excessive intake of any one food. Some authors have suggested starting newborn infants in highly allergic families on milk-free diets, using soybean or synthetic milks or formulas made with meat protein. This would appear to deserve consideration in some extreme cases. Some infants, however, have a low tolerance for soybean milk. Glaser and Johnstone[6] attempted the routine use of a soybean milk for normal newborn infants. They found that 13.5 per cent of their infants developed diarrhea or other gastro-intestinal symptoms while being fed only this soybean preparation. It would appear logical to diminish the potency of the more common allergens, such as milk, egg, wheat, and fish oils, by introducing them into the diet in a denatured form or to avoid them whenever possible.

The following general plan of infant feeding for potentially allergic infants is similar to the

plan advocated by Shulman.[7] The physician's first concern for any newborn infant who cannot receive breast milk is a formula on which the infant can thrive. Evaporated milk would appear to be the first choice in most cases, for the antigenic power of the lactalbumin in evaporated milk is low, although, of course, the infant may be sensitive to the protein casein. Evaporated milk should be continued until the infant is approximately one year of age if it is tolerated well. After one year the absorption of undigested protein through the intestinal tract is less likely to occur. The relative potency of corn as an allergen is still somewhat controversial.[8, 9] However, it would be advisable to use a carbohydrate such as Dexin in the formula of these infants rather than a carbohydrate made of corn syrup. Vitamin C can be added in the form of ascorbic acid, and synthetic vitamins A and D in aqueous dispersion can be prescribed to avoid fish oils. The intestinal upsets which may follow excess dosages of the B complex vitamins should be avoided. Ratner, et al,[10] have recently reported that the local dermatitis and gastro-intestinal symptoms generally attributed to orange juice are not always allergic in character but represent a pseudo-allergic irritation produced by the primarily toxic orange peel oil. They found a proprietary orange juice to be devoid of orange peel oil and orange seed protein which may have allergenic properties. These workers, therefore, stated that since this proprietary orange juice was free of these substances it could be offered to infants without fear of reactions.

Shulman[7] and others have suggested that in view of the ease with which undigested protein is assimilated through the gastro-intestinal tract of the infant caution be exercised as to the time of addition of other foods to the diet of the potentially allergic infant. He arbitrarily chooses the age of three or four months for the addition of semi-solid foods. Rice cereal is the least allergenic cereal and is a logical food to be introduced first. Commercial mixed cereals for infants which contain common allergens such as wheat germ, corn meal, farina, and oat meal should be avoided. Egg might be introduced at about five months in the form of hard boiled yolk with egg white, a much more potent allergen, deferred until one year. The addition of single fruits, vegetables, and meat such as lamb might be started at six or seven months with intervals of one to two weeks between additions. Mixed vegetables and commercial soups which may contain "fillers" such as barley should not be added until one year. Raw foods should be avoided throughout infancy, especially when the infant is sick, as the gastro-intestinal tract is more permeable to allergens following an illness.

DIAGNOSIS AND TREATMENT

The diagnosis and treatment of diarrhea of allergic origin in infants and children can perhaps best be considered together, for, aside from a few laboratory procedures which are frequently of little help in establishing the diagnosis, both the diagnosis and treatment rest on the identification and removal of the offending allergens in the diet. Before the physician embarks on a trial elimination diet for any type of gastro-intestinal allergy, he must make every effort to rule out all nonallergic causes of diarrhea, such as coeliac disease, cystic fibrosis of the pancreas, infectious diarrheas, tuberculous enteritis, chronic ulcerative colitis, amoebiasis and other parasitic infections, regional ileitis, congenital intestinal malformations, and intestinal neoplasms. Limitations of time prevent the consideration of the differential diagnosis of these conditions in this paper.

If the infant or child in question appears to fit into one of the previously mentioned types of gastro-intestinal allergy, a great deal of information may be obtained from a detailed, carefully taken family and dietary history which includes every food or medication which the child receives. After the history has been considered in detail, further diagnostic aid may be obtained by the elimination of certain foods from the diet, keeping in mind that milk, egg, wheat, and fish oils are the most common offenders. The child's diet, however, must never fail to meet the needed nutritional requirements for optimal health and growth while the offending foods are being sought. Fortunately, today it is relatively easy to supply the needed calories, minerals and vitamins to the infant or child even though the diet has been severely restricted. It should be kept in mind that relief of symptoms following the removal of specific foods from the diet does not necessarily prove the diagnosis of gastro-intestinal allergy, for there may be other qualities about the food, entirely apart from allergy, which may cause the patient's symptoms.[11]

In the newborn infant who is receiving a diet limited to milk the problem may be relatively simple. If allergic gastro-intestinal symptoms appear while the infant is receiving a balanced evaporated milk formula with a proper added carbohydrate, it is safe to assume that milk casein is the offender and that no type of animal milk will improve the condition.[7] A close biologic relationship between goat, cow and human casein has been demonstrated[12] and, therefore, casein-sensitive patients do not benefit when the milk ingested is changed from one of these types to another. Soybean milk has high biologic value and provides for normal growth and development if adequate vitamins are added. It is high in unsaturated fatty acids and provides essential nutritional values of protein, fat, carbohydrate and minerals. These is no animal protein present in soybean milk. It is fairly economical, readily available, and easily prepared. When loose stools appear with the use of soybean milk, they may often be controlled by the addition of one teaspoon of a kaolin-pectin preparation in each of the infant's bottles. If soybean milk is not accepted or tolerated by the infant, other milk substitutes such as an amino acid milk formula or meat formula may often be tried with success. If milk is a major offending allergen, relief of symptoms should be noted within two or three days after its complete removal. If the infant is not relieved, further study and treatment will be necessary.

In the case of the older infant or child, it is frequently an extremely difficult problem to determine the underlying allergen. Many different types of elimination diets have been advocated by various authors, those offered by Rowe[13] having been used most often. Standardized elimination diets should be employed only in the absence of any help from the history and after a trial omission of the common offenders such as milk, egg, wheat, and fish oils. Any diet will necessarily be varied by the physician's clinical impressions as to the etiology of the symptoms. The value of the carefully taken history cannot be overemphasized. Detailed information regarding elimination diets may be obtained in pediatric texts, and no attempt will be made here to present the details of such diets. The addition of single foods to the basic elimination diet has been variously advocated at four-day to three-or-four week intervals. A relatively conservative regime, though not always necessary, will reduce the number of treatment failures. Drugs are rarely helpful or necessary except in the acute phases of gastro-intestinal allergy. The antihistamines are of no significant value in treatment or diagnosis.[3]

Laboratory tests are unfortunately of little aid in diagnosis. Roentgenologic studies with the use of a barium-in-water meal followed in a few days by a similar examination plus the suspected food will frequently show, in the second test, delayed gastric emptying time and changes in intestinal motility.

Most workers have felt that skin tests are unreliable when employed in the diagnosis of gastro-intestinal allergy. Although a positive skin reaction is regarded as indicating hypersensitivity of the skin to the injected antigen, it cannot be assumed that a similar hypersensitivity to the same antigen exists in the gastro-intestinal tract. Clinically it has been found that the correlation between both positive and negative cutaneous reactions and the occurrence of gastro-intestinal symptoms is often poor. In 1948, Nance[14] reported his experiences with the staining of mucus in stools for the presence of eosinophiles. He stated that he found this test to be a great aid in the identification of allergic diarrheas. Eosinophiles also have been reported in the mucus of stools of patients with necrotic neoplasms of the intestine, chronic ulcerative colitis, and amoebic dysentery, as well as in allergic diarrheas. Though the value of this relatively simple test is questioned by some workers, it may serve as corroborating evidence in some cases. Stool analyses of fat content, vitamin A absorption curves, and glucose tolerance curves are not diagnostically helpful.[3] Routine blood counts, as well as fluctuations in the number of eosinophiles, leucocytes, and thrombocytes in the peripheral blood, have not proved to be of practical help to most pediatricians.

SUMMARY

A brief discussion of diarrheas due to gastro-intestinal allergies has been presented with emphasis on the prevention, diagnosis and treatment of this condition. It has been stressed that the diagnosis of gastro-intestinal allergies must be made in most cases on clinical observations.

REFERENCES

1. Clein, Norman W.: Cow's milk allergy in infants. Ann.

Allergy. 9:195-204, (March-April) 1951.
2. Round Table Discussion: Present day concepts of allergy. Ped. 6:652-655, (Oct.) 1950.
3. Rothmann, Phillip E.: Diarrhea of allergic origin. Am. J. Dis. Child. 86:201-210, (Aug.) 1953.
4. Black, J. Harvey: Do you need to know about allergy? Ill. Med. J. 105:5-10, (Jan.) 1954.
5. Loveless, Mary H.: Milk allergy: a survey of its incidence; experiments with a masked ingestion test. J. of Allergy. 21:489-499, (Nov.) 1950.
6. Glaser, J., and Johnstone, D. E.: Soybean milk as a substitute for mamallian milk in early infancy. Ann. Allergy. 10:433, 1952.
7. Shulman, Maurice H.: Prophylaxis against allergy. N. Eng. J. Med. 239:391-395, (Sept. 9) 1948.
8. Randolph, T. G.: Food allergy. Med. Clin. North America. 32:245-263, 1948.
9. Loveless, Mary: Allergy for corn and its derivatives: ingestion test for its diagnosis. J. of Allergy. 21:500-509, (Nov.) 1950.
10. Ratner, Bret; Untracht, Samuel; Malone, H. John; and Retsina, Mary: Allergenicity of modified and processed foodstuffs. J. of Ped. 43:421-428, (Oct.) 1953.
11. Round Table Discussion: Food allergy in children. J. of Ped. 16:653-672, (May) 1940.
12. Anderson, A. F.: Schloss, O. M.; and Stuart, H. C.: Biologic relationship between cow's, goat's, and human caseins. Am. J. Dis. Child. 44:1178-1186, (Dec.) 1932.
13. Mitchell and Nelson: Textbook of Pediatrics. Ed. 5, W. B. Saunders Company, 1950, p. 1616.
14. Nance, F. D.: Stool eosinophilia in gastro-intestinal allergies of infancy. J. of Ped. 33:313-317, (Sept.) 1948.

‹ ‹ ‹ › › ›

M.S. a Yankee disease

Recent epidemiologic and genetic data in association with clinical and pathological observations are compared for multiple sclerosis and amyotrophic lateral sclerosis. The most striking characteristic for multiple sclerosis is its rarity in the tropics and subtropics and its relatively high prevalence in regions with a colder climate. No selectivity for race or nationality within any particular area was observed. The importance of a genetic factor in multiple sclerosis is equivocal and the data strongly suggest that an exogenous factor is of prime importance. On the other hand, the geographic distribution of amyotrophic lateral sclerosis does not vary in the countries and regions studied except for the Mariana Islands, where this illness is exceedingly prevalent. No external etiologic factor has been discovered on Guam in the Mariana Islands or elsewhere, but the occurrence of numerous cases in some families and none in neighboring families was noted. In a recent genetic study of amyotrophic lateral sclerosis, a large number of pedigrees indicative of dominant inheritance were collected. It is uncertain whether the sporadic cases of amyotrophic lateral sclerosis that still account for the majority of all cases observed in practice have a basic etiology differing from that of the hereditary form of the disease. The data strongly suggest that for amyotrophic lateral sclerosis exogenous factors are of little importance etiologically; it is inferred that this disease is due to some yet undetected metabolic disturbance that develops in adulthood and often is inherited. *Leonard T. Kurland, M.D., et al. Multiple Sclerosis and Amyotrophic Lateral Sclerosis. New England J. Med. April 28, 1955.*

‹ ›

Diet in the aged

Medical and social factors were listed more frequently than economic reasons for changes in eating habits with advancing years. Medical reasons accounted for changes in eating habits in 41 per cent of the cases, social in 30 per cent, economic in 20 per cent, teeth in 4 per cent, inaccessibility of food stores in 2 per cent, and other factors (mainly lack of cooking facilities) in 9 per cent. Vitamin supplements were consumed by 44 per cent, with 29 per cent of this group doing so on doctors' recommendations. Laxatives were taken routinely by 55 per cent, varying from three times a month to once or more daily. *Dietary Habits of Elderly People. Nutrition Rev. March 1955.*

COOK COUNTY HOSPITAL CASE RECORDS

An Unusual Complication of Sigmoid Volvulus

Thomas W. Samuels, M.D., Chicago

SIGMOID volvulus is not an infrequent occurrence. The symptoms produced are usually of an acute nature, although the condition may be chronic and recurrent. Marked abdominal distension is found due to the mechanical bowel obstruction incident to the volvulus. If the obstruction is only partial at the onset, abdominal distension may be expected to increase more slowly. If there is doubt as to the etiology of the distension, percussion and/or an upright plain roentgenogram of the abdomen will be of help.

A 38 year old man, with known multiple sclerosis for fourteen years, was admitted to the hospital with the chief complaint of generalized abdominal pain. Three days previously he had complained of the gradual onset of mild, intermittent, cramping abdominal pains. The pain was not associated with vomiting but there was some degree of constipation. Mineral oil was prescribed on the first day of illness. The patient began to have frequent, loose, brown stools with some relief of pain. However, the cramping returned and the abdmen became somewhat swollen.

Obstipation was noted on the second and third day and the abdomen became markedly distended. At this time a diagnosis of cirrhosis was made and the protuberant abdomen was thought to be due to ascites. Abdominal paracentesis was performed in the patients home with removal of "one cupful of brownish material". Following this the patient experienced a sudden onset of severe generalized abdominal pain. He was advised to enter the hospital immediately. However, he was first seen in our admitting room seven hours after the paracentesis.

Examination showed an acutely ill white male. The temperature was 101.2, blood pressure 160/100 and pulse 112. The abdomen was markedly distended. There was generalized tenderness to palpation. A small paracentesis wound was seen in the midline just below the umbilicus. No bowel sounds were heard. There was partial paralysis of the left arm and leg with decreased cough reflex. This was due to the multiple sclerosis.

The x-rays of the abdomen (Figure 1 and 2) showed dilated loops of large and small bowel, possible volvulus and free air in the peritoneal cavity. This suggested the preoperative diagnosis of instrumental perforation of a sigmoid volvulus.

Preoperative preparation included intravenous fluids, gastric suction with a Levine tube and antibiotics.

Under general anesthesia a left paramedian incision was made. Upon incising the peritoneum, air under pressure escaped. A grossly dilated loop of sigmoid colon and several loops of di-

Senior Resident in General Surgery, Cook County Hospital, Chicago, Illinois

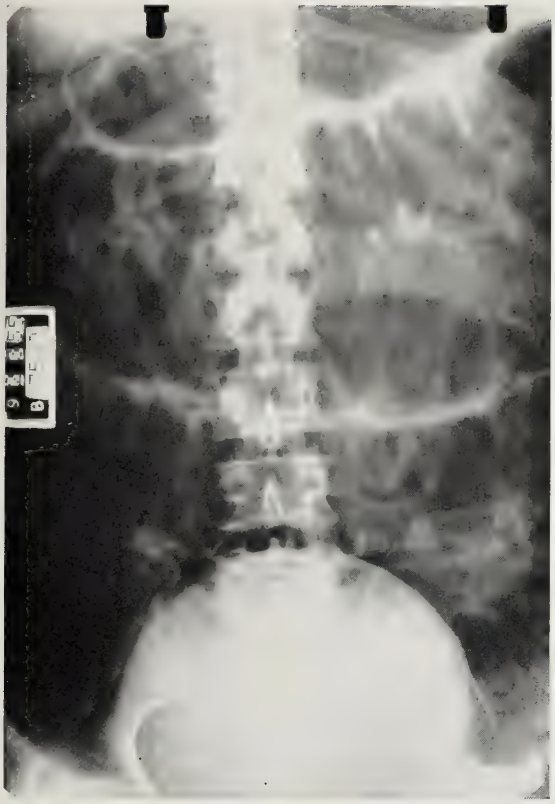


Figure 1. Roentgenogram of the abdomen in the left lateral decubitus position showing marked displacement of the liver by free air in the peritoneal cavity, also distended loop of large bowel suggesting a volvulus.

lated small bowel were noted. There was a small perforation in the distended loop of sigmoid colon apparently caused by the paracentesis trocar. A loop of ileum was caught in the twisted mesentary of the sigmoid volvulus produring a mechanical small bowel obstruction. The small

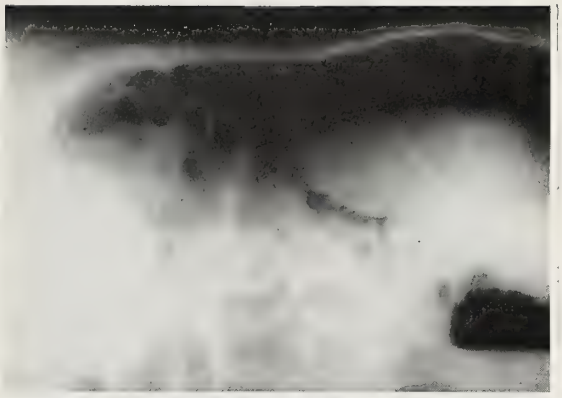


Figure 2. Roentgenogram of the abdomen with the patient in the supine position showing multiple loops of large and small bowel.

bowel was somewhat ecchymotic but it was viable. There was no evidence of gross fecal contamination of the peritoneal cavity. The sigmoid colon was mechanically clean and the walls were not edematous. The volvulus was untwisted, thereby releasing the obstructed small bowel. The redundant sigmoid colon was resected and an end to end anastomosis affected. The abdominal wall was closed in layers with interrupted steel wire.

The post operative course was complicated on the second day by discovery of a partial atelectasis. This was due to the patients inability to cough properly. Bronchoscopy allowed a large quantity of thick mucoid material to the aspirated. He received frequent tracheal aspiration, antibiotics and expectorants. On the seventh postoperative day the chest was clear and the temperature normal.

His subsequent recovery was uneventful.

1825 W. Harrison St.

Pathology Conferences

Edwin F. Hirsch, Department Editor

CONGENITAL STENOSIS of the Neck of the Urinary Bladder

WILLIAM J. BAKER, M.D., AND EDWIN F. HIRSCH, M.D., CHICAGO

A WHITE youth aged 10 years entered the pediatric service of St. Luke's Hospital on July 21, 1953 in the care of Doctor C. Edward Stepan and died on July 26, 1953. The boy had been lethargic, hoarse and dyspnoeic during the first few days of July, and on the 15th had a fever of 101°F. Then again he became dyspnoeic and so lethargic that he did not arouse for his meals. Bowel movements were normal and during the morning of the day of admission he urinated three times without pain or gross blood. His temperature was 97°F., the pulse was 118 and the respirations were 34 per minute, and his blood pressure was 142/72 mms. Hg. His pupils were regular, equal and reacted to light, but the boy had labored breathing and remained in coma. The lungs were clear; palpable masses were not found in the abdomen; and neurological examinations disclosed nothing significant.

The blood had 2,540,000 red blood cells and 18,200 leukocytes per cubic mm., the hemoglobin was 6 gms. percent. The neutrophil leukocytes of the blood were in excess (73 percent). The non-protein nitrogen of the blood was 253 mgms., the sugar 124 mgms., the plasma chlorides 460 mgms. percent and the CO_2 combining power was 19.2 volumes percent. The pale straw-colored urine had a pH of 5.5, a specific gravity of 1.008, contained 200 mgms. percent albumin, a few red blood cells, but no sugar.

The youth was given plasma, whole blood and other solutions intravenously. A cystoscopy on July 26 demonstrated dilated ureters, but no obstruction of the neck of the urinary bladder. He became anuric and no urine was excreted through the ureteral catheters. Death occurred within a few hours.

The essential portions of the anatomic diagnosis of the trunk examination are:

Marked congenital stenosis of the lumen of the prostatic urethra;

Marked bilateral hydroureter, hydronephrosis and atrophy of the kidneys;

Marked dilatation of the lumen and muscular hypertrophy of the urinary bladder;

Acute hemorrhagic colitis — uremia;

Hypertrophy of the myocardium and dilatation of the lumen of the left ventricle of the heart;

Chronic passive hyperemia of the lungs, liver and spleen; etc.

The body of this white boy weighed 50 pounds

From the Henry Baird Favill Laboratory of St. Luke's Hospital, Chicago

and was 102 cms. long. There were multiple needle puncture wounds of the arms and several venesection wounds of the ankles. The abdomen contained about 500 cc. of a clear limpid yellow fluid. The emphysematous lungs had a hypostatic edema and hyperemia. The right lung weighed 200 gms., the left 160 gms. The heart weighed 130 gms. and had a moderate hypertrophy of the myocardium of the left ventricle. The fluctuant right kidney was 9 cms. long, 5 cms. wide and 3 cms. thick. The dilated cone-shaped right renal pelvis extended out 7 cms. from the hilum of the kidney and was 6.5 by 3 cms. It was continuous with the tortuous and hugely dilated ureter which had an "S" shaped angulation just below the uretero-pelvic junction. In the midportion the outside diam. of the ureter was 2.5 cms. The renal pelvis and the major and minor calyces (Figure 1) were markedly dilated. The parenchymal tissues in many places were reduced to a layer 1 mm. or less thick. The fluctuant left kidney was similar. Partially collapsed it was 8.5 by 4.5 by 3.5 cms. The left ureter was dilated, had a sinuous angulation at the upper level and in the mid level had an outside diam. of 2 cms. The liver weighed 640 gms., the spleen 60 gms.; both were hyperemic. The lining of the ascending colon was hyperemic and had many submuscosal hemorrhages.

The urinary bladder was distended to 6.5 cms. above the symphysis pubis. The hypertrophied wall was 8 mms. thick. The lining was trabeculated and above the trigone were multiple fibrous thickenings 6 to 8 mms. in diam. The ureteral orifices of the urinary bladder were dilated. The prostate was small, the prostatic urethra was markedly narrowed just beyond the verumontanum. Valve-like structures were not present and a probe 2 mms. in diam. could be passed through the prostatic urethra. When the tissues of the neck of the urinary bladder were folded together the swollen verumontanum formed a ridge of tissue that practically occluded the lumen of the prostatic urethra. The entire membranous and penile urethra were examined and the channel was widely patent.

Histologic examination of the kidneys demonstrated a marked atrophy and fibrous tissue replacement of the parenchymal tissues.



Figure 1. Photograph illustrating the dilated urinary bladder, the marked bilateral hydroureter and hydronephrosis with renal atrophy caused by the congenital stenosis of the prostatic urethra.

COMMENT

Obviously this youth had a congenital obstruction of the neck of the urinary bladder. The obstruction was caused by a large edematous verumontanum, and a narrow prostatic urethra. With obstruction of the vesical neck, the ureter and kidney on each side are affected. Occasionally one side is damaged much more than the other. The wall of the urinary bladder of this boy was hypertrophied because of the urinary obstruction and associated increased intravesical pressure. Later such a bladder wall can become paper thin, atonic and the patient has an overflow incontinence. Because of the urinary retention the uretero-vesical valve function diminishes and the intracystic pressure is transmitted into the ureters and renal pelves. Exaggerated peristalis of the ureters occurs but the increased hydrostatic pressure dilates the ureters longitudinally as well as in diameter. Some ureters become greatly lengthened and tortuous. Then, as has happened

in this boy, the urinary retention pressure damages the kidneys. The secretory functions of the kidney diminish as the effects of the obstructed urine destroy the renal parenchyma. The photograph in Figure 1 illustrates clearly the final stages of this disorder. Cystotomy enables some restoration of renal function if the damage to the kidneys has not progressed too far. However, without relief of the obstruction, even in the absence of infection, renal function decreases and finally death in uremia occurs.

The early diagnosis of this disorder is not easy, unless cystitis or overflow incontinence in a child attracts attention to some urinary tract disorder. An alert parent may observe that the child has difficult micturition and then seeks medical advice. Many children with this bladder neck obstruction reach adolescence and have symptoms of renal ricketts. They are small in stature, have a dry skin and tongue, the palor of an anemia, and continually are thirsty. If not infected, the urine is dilute and like water. The chemical constituents of the blood at first have slight changes but later the non-protein nitrogen elements are elevated markedly. Intravenous urography is excellent as a diagnostic procedure but should be supported by retrograde urological examinations to demonstrate fully the urinary tract disorder. Cystotomy drainage for a long time is indicated before revision of the bladder neck is attempted. Some prefer to make this revision from within the bladder, others use a transurethral procedure to relieve the obstruction.

‹ ‹ ‹ › › ›

Aspirin versus ACTH

The three rheumatic fever groups on ACTH (162 cases), cortisone (167 cases), and aspirin (168 cases) were remarkably similar in most respects at the start of the trial. The results of this treatment were measured in terms of separate manifestations of the disease — namely, fever, pulse rate during sleep, erythrocyte sedimentation rate, joint involvement, chorea, erythema marginatum, and nodules. The patients in the three groups also were compared for such aspects of the status of the heart as heart size, atrioventricular conduction time, and murmurs and, in particular, those indicative of serious illness — congestive heart failure and pericarditis. The results, for the most part, were clean cut. There was no evidence that any of the three agents resulted in uniform termination of the disease. On all three treatments, fresh manifestations developed during treatment in some cases. Therapy with either of the hormones produced prompter control of certain acute manifestations but this more rapid disappearance was balanced by a greater tendency for the acute manifestations to reappear for a limited period on cessation of treatment. The use of the hormones also led to more rapid disappearance of nodules and soft systolic murmurs. At the end of a year, however, there was no significant difference between the three treatment groups in the status of the heart. During the period of treatment, observation, and year of follow-up examination there were only six deaths among all the patients admitted to the study. *Editorial. ACTH, Cortisone, and Aspirin in Acute Rheumatic Fever. New England J. Med. March 10, 1955.*

EDITORIALS

A century of gynecology

Gynecology as a specialty was one hundred years old last May. Prior to that time, the practice was "limited to the treatment of erosion with silver nitrate, leukorrhea with oak bark solutions and uterine prolapse by the employment of a ball pessary."

Most of the credit for the advances made goes to J. Marion Sims. Dr. Sims successfully repaired a vesico-vaginal fistula, a condition that previously was considered incurable. It was prevalent at that time because of the poor obstetrics of the day. His technique was hailed as a major discovery.

Most of his work had been done on his slave patients. He operated 40 times on 3 patients, and 30 times on 1 of them during his experimental period, before cure was effected. These patients, though they never shared in the glory, deserve credit for their contribution to the advancement of medical science.

This discovery prompted Dr. Sims to move to New York where he became established in the practice and teaching of gynecology. He was an original founder of the Woman's Hospital in New York, the first hospital in the world dedicated to the treatment of diseases peculiar to women.

‹ ›

Drugs in epilepsy

The "dione" drugs have been used in the treatment of epilepsy since 1941. They are derivatives of oxazolidine-2-4-dione, and include Propazone,® Tridione,® Paradione,® Dimedione® and Malidone.®

Livingston and Boks[1] compared the efficiency of these products in petit mal and minor motor seizures. Tridione was found to be the most effective for petit mal; the spells were controlled completely in 546 (68 per cent) of 804 children. The drug was ineffective against minor motor and major seizures. In their opinion, the drug is safe to use when the patients are supervised adequately, with periodic physical examinations, and complete blood counts.

Paradione was next most effective, followed by Dimedione in the control of petit mal. The results with Propazone and Malidione were disappointing. The authors also used glutamic acid and Diamox® with poor results.

The diversity of opinion between their results and those of other investigators was explained by the fact that diagnosis of petit mal is used loosely to include many types of epileptic seizures, particularly the minor seizures of the akinetic and myoclonic type.

‹ ›

Interstate Postgraduate Medical Association

The International Medical Assembly, planned by the Interstate Postgraduate Medical Association of North America will be held at the Municipal Auditorium, Milwaukee, Wisconsin, November 14-17.

With the meeting scheduled in Wisconsin, every effort has been made to cooperate with the officers, so that members of the medical profession in Illinois who desire to take advantage of

1. Livingston, Samuel, and Boks, Lydia L. Use of the Dione Drugs in the Treatment of Epilepsy in Children. New England J. Med. **253**:138-142, 1955

this outstanding session, will be kept informed about the plans, the program, and the hotel accommodations available.

Dr. Edwin S. Hamilton of Kankakee, Dr. Willis I. Lewis of Herrin, and Dr. J. Mather Pfeiffenberger of Alton are all members of the Board of Trustees. Doctor Pfeiffenberger is Speaker of the Assembly; Dr. Warren Cole, Dr. Hamilton and Dr. Pfeiffenberger are all members of the Program Committee.

Through the efforts of the Executive Director, Mr. Roy T. Ragatz of Madison, Wisconsin, preliminary notices have been mailed to all members of the Illinois State Medical Society. The preliminary program has been printed and is ready for distribution.

Many outstanding Illinois physicians are scheduled to present scientific papers: Paul C. Bucy, Warren H. Cole, Walter L. Palmer, Warren W. Furey, Wayne B. Slaughter, Ralph A. Reis, Roland P. Mackay, Carlo Scuderi, Martin H. Seifert, and John J. Procknow.

If you desire a copy of this complete program, you may secure it by writing

The Interstate Postgraduate Medical Association,
207 Gay Building
Madison 3, Wisconsin

In the meantime, may we suggest that you mark your calendars for November 14-17, and plan to attend this meeting in Milwaukee.

‹ ›

Conference of Mental Health Representatives

On November 18 and 19, the Council on Mental Health of the American Medical Association is sponsoring the second annual conference of "Mental Health Representatives of State Medical Associations". The conference will open at 9:30 a.m. on Friday, November 18, in the auditorium at A.M.A. Headquarters, (535 North Dearborn Street, Chicago), and will close at 12:00 noon on Saturday, November 19.

At the first annual conference held last year, 36 states were represented, and there was unanimous agreement that the meetings should be held each year.

At the 1955 session the meeting will be opened with a welcoming address by Dr. Elmer Hess, President of the American Medical Association. The subjects which will be discussed are:

1. The narcotics problem as it effects general medicine.
2. Methods of integration of mental illness and public mental hospitals with the total medical community.
3. Our future relationships with clinical psychologists.
4. A discussion period in which general problems are presented:
   - A. Commitment problems
   - B. Establishment of psychiatric units in general hospitals
   - C. Setting up psychiatric consultation services for the general medical men
   - D. Development of committees on mental health at the county medical society level
   - E. Other subjects introduced from the floor

A dinner meeting at the Drake Hotel (given by the Council on Mental Health) will be held on the evening of Friday, November 18.

The Saturday morning session (November 19) will discuss:

1. What a mental hygiene clinic should be from the viewpoint of general medicine. This will include a discussion of proper sponsoring groups, staffing, relationship to school systems, and possible interference with private practice.

The Illinois State Medical Society will be represented by the members of its Committee on Mental Health.

‹ ›

Interest in medical history

There is considerable lay interest in Volume II of "History of Medical Practice in Illinois."* Newspapers have given it glowing reviews. Recently, the Illinois Central Railroad Magazine devoted a column to the book. Dealers from many parts of the country are placing orders.

This interest in lay circles is not surprising. Here is a book which presents medical history in a manner which appeals to the general public as well as to the medical profession.

However, notwithstanding the value of the book to physicians, there is an apathy on the part of doctors.

Every physician should have a copy. The book goes beyond local history. Actually, it is an account of the development of medicine in gen-

* Arranged and edited by David J. Davis, M. D. Published by Illinois State Medical Society. $10.00. Address Secretary's office, 224 South Main St., Monmouth, Illinois.

eral. It is an excellent reference volume for those who prepare papers for scientific meetings or publications, or who speak before professional or lay groups.

It is a "tonic and sedative" after a hectic day in hospital, office or homes. Fifteen minutes of reading will bring relaxation. The trials and tribulations of today's medical practice will be forgotten in admiration of the work of the physician in the last half of the 19th Century, the period covered by Volume II.

It also would not be amiss for physicians to have a copy of the history on their reception room tables. It will be of special interest to the person seeking knowledge while waiting. To some patients, the book will be a welcome change from magazines.

Dr. Nicholas Senn (p.83) in 1893 said: "We live in an age of great unrest in medical literature. Books written only yesterday are old today."

Volume II of "History of Medical Practice in Illinois" does not fall into that category. It will never grow old, and therefore, the book should be in the library of every physician. The investment will pay good dividends.

‹ ›

Alien physicians studying in the United States

In the August 13 issue of the Journal of the American Medical Association, there was an interesting article on graduates of foreign medical schools coming to the United States for additional study. Taking the year 1954-55 for study, it was shown that more than 5,000 foreign physicians came into this country from the foreign schools. They came from 83 different countries for internship and residency training at hospitals in 42 states, the District of Columbia, Hawaii, Puerto Rico and the Canal Zone.

The survey of 1,177 hospitals among those approved for internships and residencies by the A.M.A. Council on Medical Education and Hospitals, indicated that there were at least 5,036 alien physicians in training, and this does not include immigrants and displaced persons. Countries sending the most physicians to the U.S., were the Philippines, Canada, Mexico, Germany and Turkey, although a number of other countries sent physicians to the U.S. for additional training.

Of this number, 620, (12.3 per cent) were women. By contrast, of the American school graduates from 1952 through 1954, only 5.2 to 5.7 per cent were women. More than 2,000 of these alien physicians were in the United States on their own resources. Others were sponsored by at least 67 different agencies, including their own or the U. S. government, the United Nations, or religious, educational or philanthropic organizations.

In addition to the large number of physicians in hospital, internship-residency training, others visited the United States as observers, professors, or guest participants in research. This group represented 21.5 per cent of the foreign educators who visited this country during the year under study. Again by way of contrast, only 3.6 per cent of all American educators visiting other parts of the world during the year, were listed under medicine.

This report again shows that the trend of 50 or more years ago, when many physicians believed it necessary to complete their medical education by spending months or years in European centers, has been reversed.

‹ ›

Statutes of public health significance enacted by 69th General Assembly

The following bills have become law. All of these appear to have some public health significance, direct or indirect:

S 15 Creates Commission on Care of Alcoholics.

S 36 Appropriates $140,000 for construction and sewer improvements at Carbondale in connection with Southern Illinois University.

S 76 To revise and codify the laws in relation to rights of drainage, the construction, maintenance and repair of drains, ditches and levees for agricultural, sanitary and mining purposes, and the organization and operation of drainage districts.

S 101 Requires the Department of Agriculture to assign numbers to Illinois cheese factories, the number to appear on all products.

S 105 Removes hospitals, which deny admission to any persons because of race, color or creed, from tax exemption.

S 142 Provides for hospitalization for inmates of Illinois State Farm suffering from tuberculosis.

S 163 Creates commission of 5 members from each house and 5 citizens appointed by the Governor to study existing knowledge and programs relating to the problems of the aging and the aged

in Illinois with a view to determining what steps can be taken to provide a better integration of this group in the social and economic life of the State. To report to 70th General Assembly.

S 194 Creates commission to study traffic in narcotics. Three from each house and three named by Governor. Governor's appointees to include one person who has had judicial experience, one who has been or is a member of the Parole and Pardon Board, and one who is experienced in prison administration. $30,000 appropriation.

S 206 Refrigerated warehouse regulation act. Sets up sanitary conditions under which refrigerated warehouses must be operated and places licensing and inspection powers with Director of Agriculture. Prohibits storage of food for more than 24 months and makes illegal the representation as "fresh" any food stored for more than 30 days. Repeals cold storage act of 1917.

S 225 Gives cities right to purchase, extend, improve and operate waterworks and to acquire property including that now used for highway purposes for water supply purposes. Extends jurisdiction of city to prevent pollution to 20 mile area instead of present 5.

S 248 Amends section 6.06 of the civil administration code. Creates Advisory Board on necropsy service to coroners in Department of Public Health. Governor to name board to consist of 9 members to include three members who are licensed to practice medicine, 2 in field of pathology, 3 who are elected coroners. Members to serve without compensation other than expenses.

S 265 Provides for the disconnection of any area of land from mosquito abatement districts and prescribes procedure for carrying out such disconnection.

S 338 Appropriates $558,000 for additions to the Mt. Vernon State Tuberculosis Sanitarium and a residence on site.

S 393 Excludes from licensure by Department of Public Health any hospital or care facility maintained by any university or college established under state law and supported principally by public funds raised by taxation.

S 403 Provides pupils shall not be required to take or participate in instruction on diseases if parent or guardian files written objections thereto. Instruction in sanitation and hygiene not prohibited.

S 458 Provides that in public schools, instruction shall be given in safety education.

S 481 Authorizes Department of Public Health to provide anti-polio vaccine to the people of the State and makes an appropriation of $1,000,000 therefor.

S 489 Amends sections 72-1, 72-3, and 72-4 of the cities and villages act. Provides that in cities of more than 500,000, the mayor with the approval of corporate authorities shall appoint a board of 5 directors of the public tuberculosis sanitarium. Pegs tuberculosis tax levy at $5,500,000 annually until 1958 when rate is reduced to $5,250,000.

S 495 Biennial appropriation for the Department of Public Health ($15,484,150 General Revenue Fund; $14,319,220 Federal Public Health Funds).

S 512 Provides for a commission of 3 from each house and 3 named by Governor to investigate and prepare a program for the protection of lake fish against pollution, parasites and other destructive causes.

S 539 Amends trailer coach park licensing act. Provides any coach resting entirely on a permanent structure, with wheels, etc., removed, shall not be construed as a trailer coach. Other amendments.

S 569 Requires Department of Public Health to change original birth certificates of Illinois residents in cases where operations are performed changing the sex designation of the person.

S 577 Creates atomic power investigating commission to study social and economic impact on civilian use of atomic power. Commission to consist of 3 members of the General Assembly, 3 persons from industry, 3 from labor, 3 scientists appointed by the Governor, and the Directors of Public Health, Public Welfare, and Civil Defense as ex-officio members.

S 582 Creates commission of 3 from each house and 5 by Governor representing agriculture, municipalities, conservation, public health and industry to study the water and drought situation in Illinois.

S 587 Repeals section 7 of act requiring labeling of materials used in bedding.

S 595 Amends cities and villages act in relation to condemnation proceedings in connection with construction or acquisition of any water works system.

S 658 Requires annual tuberculosis tests for all school employees at least 5 months prior to opening of school year. Prohibits employment of any infected employee in school system who comes in contact with students.

S 667 Prohibits sale of unpasteurized milk after June 30, 1956 with certain exceptions.

S 693 Licenses and regulates the practice of pharmacy. Repeals existing act.

S 734 Amends section 4 of trailer coach parks act. Requires compliance with all county zoning ordinances in establishment of such parking areas.

S 737 Creates plumbing laws commission of 3 from each house and 3 named by Governor to study need and feasibility of a State plumbing code to insure quality work, etc. Would report to next legislature.

S 758 Appropriates $780,000 to Department of Public Health for special care of premature children.

S 770 Puts minimum of 500 gallons capacity on septic tanks. Does not apply to owner occupant of a single family dwelling who wishes to install his own septic tank to serve his own individual

dwelling and who further complies with all other State and local laws regulating septic tanks.

H 58 Creates a Northeastern Illinois Metropolitan area local governmental services commission of 20 members to study services relating to public health safety, welfare and convenience which are generally considered to be the responsibility of local governments. To report to 70th General Assembly.

H 70 Amends section 25 of the counties act. Authorizes county boards with the consent of county employees to deduct from pay checks premium payments for group health, accident, hospital and medical insurance.

H 86 Regulates the possession, delivery, sale or exchange of hypodermic syringes, hypodermic needles, and similar instruments. Requires sales of these items to be registered with the Department of Registration and Education.

H 133 Exempts from the provisions of the trailer coach park regulation act any park on state or county fairgrounds for a total two-week period before, during and after the holding of a fair.

H 195 Requires county boards to establish and maintain a pound, appoint a pound-master, and fix his fees and charges.

H 241 Amends the cattle brucellosis act to provide that approved veterinarians must be accredited by the animal disease eradication branch of the federal department of agriculture instead of the federal bureau of animal industry. Increases from 4 to 6 months the age for cattle count for the discontinuance of the test and slaughter plan. Also provides added regulations concerning vaccinations.

H 242 Amends section 8 of the community sales act affecting cattle. Permits the sale of cattle under 36 months that were officially vaccinated against brucellosis when they were not less than 6 nor more than 8 months of age. Need not be accompanied by a certification of vaccination.

H 243 Amends sections 1, 4 and 5 of the swine brucellosis act to make the animal disease eradication branch of the federal department of agriculture the official certifying agency. Provides that only breeding swine over 4 months entering Illinois need have an inter-state health certificate and that only Illinois breeding swine over 4 months of age need have an official certificate before exhibition.

H 247 Amends the milk products act to make the animal disease eradication branch of the federal department of agriculture the accrediting agency. Designates approved veterinarian as one accredited by the federal department of agriculture.

H 248 Amends the milk products act to make the animal disease eradication branch of the federal department of agriculture the official accrediting agency. Raises minimum vaccination age from 4 to 6 months and strikes permission to market milk from herds which are positive on a ring test to the extent of not more than a "one-plus" agglutination.

H 319 Amends section 9 of the river conservancy districts act to give board the power to sell collected waters to public or private users when other sources of water are unavailable and when such sale does not interfere with other purposes of the act.

H 464 Authorizes municipalities to acquire, construct, own and operate within or without the corporate limits of the municipality any public utility, the product or service of which or a major portion thereof, is or is to be supplied to the municipality or its inhabitants.

H 478 Creates a sewage system investigation commission of 5 members of each house to study problems of integrating sewer systems between municipalities, drainage, water, sanitary and other such districts.

H 521 Amends section 61.13 of the counties law to permit payment of county employees' salaries without board action.

H 789 Permits downstate cities to license, locate and regulate the use and construction of rooming houses.

H 927 Permits bond issue for certain water authority expenses.

H 958 Provides that rabies inspectors who inoculate dogs shall issue tags and collect a fee fixed by county from owner.

H 1002 Permits cities to regulate lodging or rooming houses containing sleeping accommodations for 4 or more persons.

H 1031 Permits downstate cities to use vacant TB sanitarium facilities for care of convalescent or chronically ill patients.

H 1036 Permits downstate townships to sell or lease township waterworks or sewage systems.

H 1057 Give corporate authorities of a municipality the power to regulate the covering or sealing of wells and cisterns.

H 1058 Gives the County Board of each county the power to regulate the covering or sealing of wells and cisterns.

H 1066 Extends the one million dollar appropriation to the Department of Public Health for anti-polio vaccine through June 30, 1957. Emergency.

H 1141 Establishes in Department of Public Welfare a psychiatric and training program.

H 1142 Authority to train psychiatric personnel and to advance knowledge

H 1143 through research in causes and treatment of mental illness or deficiency in order to reduce the number of persons becoming mentally ill and to promote the recovery of those already afflicted.

H 1153 Excepts manufactured milk products, milk for farm workers and milk sold by producers on premises from certain requirements of the Grade A Milk Act.

MEDICAL ECONOMICS

John R. Wolff, Chairman, Walter C. Bornemeier, Edward W. Cannady, Roland R. Cross, Jr., E. F. Dietrich, W. W. Fullerton, Edwin F. Hirsch, Frederic T. Jung, W. R. Malony, Caesar Portes, William Requarth, Frederick W. Slobe.

Insurance for Freedom in Education

JOHN R. WOLFF, M.D., CHICAGO

TWO facts concerning medical education are well known to all physicians. One: American Medical education is the best in the world; and two: the cost is high.

We realize that not only must our high standards be maintained but that our efforts to improve and expand both education and research must continue in spite of increased costs, inflation, or difficulties in obtaining funds. Our enthusiasm concerning education is great. It should be. We need more doctors. We need postgraduate teaching. We need more and better refresher courses. And we always need more research.

Until recent years our medical schools had little difficulty in obtaining money. Legislatures were favorable. Philanthropists with cash were ready, willing, and able. Large foundations were looking for ways and means of distributing funds.

But now all this has changed. Legislatures have many demands on available funds. The universities need large sums of money for other projects too. Millionaire philanthropists are not easily found. The large foundations are forced to give to many sources.

The medical schools have been left by the wayside. By 1950 we heard some talk about the need for federal aid. Our medical school deans all said they did not want federal intervention, but they did want their schools to remain open. They needed money quickly.

Physicians became concerned over the plight of the medical school. Many of us pleaded — keep away from government hand outs! Beware of this socialized threat! But what to do?

In 1950 a group of doctors with vision approached the officials of the American Medical Association with a plan. The *American Medical Education Foundation* was set in action. This foundation has the sole purpose of obtaining money to distribute to the Medical Schools.

The *American Medical Education Foundation* (AMEF) then is our individual and collective organization to aid the finances of the Medical Schools.

We, the physicians of Illinois have been cognizant of this excellent plan for some time. In 1952 the House of Delegates of our State Society set up what is now known throughout the country as the "Illinois Plan." Twenty dollars of each individual annual dues were collected by our state society and donated to this fund. The individual member may ask that this money be given to a particular school or that the Foundation itself distribute the money. The cooperation of the physicians of this state is a proud one and we can hold our heads high as leaders in this great cause.

Many individuals in Illinois contribute additional funds either through the Foundation or to a Medical School directly. We stand at the top of the contributors throughout the nation.

What has the AMEF accomplished so far?

The 1954 annual report gives the answer. Briefly — Almost four million dollars have been contributed since 1951 — Note the growth in collections: 1951, $745,967; 1952, $906,533; 1953, $1,009,962; and 1954, $1,181,928.

It is estimated that our eighty Medical Schools need a total of ten million dollars annually in addition to their present financial income.

Our AMEF hopes to obtain two million from the members of the medical profession. Eight million will be raised from business, industry, and other sources.

Our job today is to get that two million per year. As of 1954 we are not doing too badly. Before we become complacent we had better note the trend towards inflation and perhaps better set our annual goal at a higher level.

How can you and I help our AMEF reach its goal?

In the first place we can boast a bit about our Illinois plan. One hundred thousand M.D.'s contributing $20.00 per year is a simple process of obtaining the present desired goal. When one is charitable it is only proper to give in a quiet unassuming manner and in a dignified humble spirit. But this is not charity. Our Illinois plan is a simple way of sharing the contribution. It's our way of paying an insurance premium towards a continuation of free unhampered medical education. So — why not sell our insurance — Let's get after those other states who say nice words, who agree with us, who say good going. Let's get them to act too.

Of course, we need not stop at this. Those who wish can increase their insurance premium. I know of no better cause.

Let us not forget that we can help toward that eight million annually we hope to obtain from business and industry. A word here and there, a mention of the Foundation to crucial people at the right time will do no harm.

Above all let's recognize our responsibility in making this Foundation work. Let's spread the gospel about the Illinois plan. As we study the 1954 annual report of the AMEF and note that Illinois ranked first in contributions let's urge our neighbors to join us — Let's remain in first place.

‹ ‹ ‹ › › ›

Keep records 8 years

As a rule of thumb, it seems desirable that account books and all other records reflecting income and expenditures should be kept until January 1 of the eighth year after the year to which they pertain. If a creditor attempts within that time to assert that a bill has not been paid, you will have your records available to dispute him. Or, if the tax collector has some question as to the proper tax liability for a given year, the correct data will be available for his perusal and for use in court, if necessary. Deeds, mortgages, leases, and other documents pertaining to real estate are seldom of burdensome volume and should be kept for an indefinite period. This should contain not only the returns but also sufficient supporting evidence to establish your income and your deductions. Papers having no particular present interest may be destroyed when their usefulness has been served. In this class fall expired policies of insurance where no loss has occurred (other than liability insurance), cancelled savings account books, contracts which have been fully performed, and similar documents. As to checks and records pertaining to items which do not have tax consequences, the 8 year period seems to present only reasonable risks, if any. *Roland J. Faricy. How Long Should One Keep Valuable Papers? Minnesota Med. May 1955.*

THE P. R. PAGE



A new battle is brewing

There is a real public relations job for medicine just ahead. And, unless the entire profession gets behind the program and works with unusual zeal, we will take another step toward socialized medicine.

That was the dire warning which came out of the American Medical Association's Public Relations Roundup in Chicago, August 31-September 1. More than 300 medical public relations people, state and county society executive secretaries and physicians attended the meeting.

The crisis which faces medicine is considered to be the most serious since the 1949-1950 attempt to enact a system of compulsory health insurance. It was brought about by an unexpected blitz in Congress when the House of Representatives by a surprise majority—372 to 31—passed H.R. 7225, an amendment to the Social Security Act. Action was speedy under a virtual gag rule.

The measure, which still has to hurdle the Senate and presidential approval, goes a long way in broadening the Social Security provisions. It would leave only a few more short steps to a complete "cradle-to-grave" socialistic system.

Medicine's greatest concern is with that section providing for compulsory cash disability benefits to those over 50. This would have a direct effect on the medical profession and the future of the American medical system.

Fortunately, Senate leaders were not stampeded by the blitz in the House. At least they promised public hearings in the second session of the 84th Congress before the bill is called up for passage. However, if the overwhelming majority in the House is any criterion of political opinion, the medical profession has a hard road ahead.

Since the victory against compulsory health insurance, there have been many skirmishes along the Washington front. These have not caused too much excitement in the profession, and many doctors have become rather complacent.

Now, there is a full-fledged campaign in the making. The counter-attack will have to be hard and on every possible front—national, state and local. Medicine will have to muster all the outside help it can. Other organizations and the public will have to be made aware of the implications and dangers of the pending measure.

There will have to be an educational program within the profession itself. This will have to be carried on by the A.M.A., state societies and county societies. Public relations and legislative committees will have to work together.

The fighting spirit of doctors will have to be aroused to such an extent that when they are called upon to contact their representatives in the Senate they will respond with zeal. There can be no "let George do it" spirit. Too much is at stake.

The reopening of Congress is about three months away. The attack of the medical profes-

sion must get under way immediately. Every county medical society in Illinois should take steps now to set up its working organization so that when the "ammunition" is passed down it can be distributed to individual doctors and to the general public.

The Committee on Medical Service and Public Relations of the Illinois State Medical Society will do its part. However, it needs the support of every county medical society and every doctor.

Notes from A.M.A. PR Roundup

Three members of the A.M.A. Board of Trustees participated in the Roundup. They were Drs. Edwin S. Hamilton of Kankakee, David B. Allman of Atlantic City and Thomas P. Murdock of Meriden, Conn. All three stressed the importance of arousing the doctors of the country to the dangers which lie ahead.

Dr. Walter C. Bornemeier, past president of the Chicago Medical Society, and Dr. H. Close Hesseltine, councilor of the Illinois State Medical Society, led a panel on professional liability. The discussion brought out that it is now common practice to bring the doctor into a suit against a hospital. Lawyers also are tending to sue for assault rather than malpractice because competent witnesses are not required.

One of the discussions concerned the reporting of annual meetings of state societies. Hart F. Page, assistant PR director of the Ohio State Medical Association, held up the August issue of Illinois Medical Journal as an example to follow. The pictorial report was praised.

Announcement was made that the firm of Bozell & Jacobs, Inc., Chicago, had been appointed public relations counsel for the A.M.A. A brief news release to the trade press said "the agency will assist the public relations department of the Association in the general conduct of its program."

Plan Medical PR Conference

The Eighth National Medical Public Relations Conference, sponsored by the American Medical Association, will be held at the Statler Hotel, Boston, November 28, just prior to the opening of the A.M.A. Clinical Session.

The conference is designed for physicians having to do with establishing public relations policies within their state and county societies.

New pamphlet for patients

To help promote a better doctor-patient relationship, the A.M.A. has issued a new 12-page pamphlet entitled "To All My Patients." It explains the roles of various persons on the medical team in providing good medical care. It also briefly discusses medical and hospital fees and insurance.

Quantities for distribution to patients may be had from the A.M.A. Public Relations Department without cost.

‹‹‹ ›››

Hepatitis in children

Infectious hepatitis in infants and young children, in contrast to the disease in adults, is not usually characterized by jaundice. Recognition of this fact has been relatively recent and, as a consequence, we are just learning about the incidence and duration of the disease, its spread, and the frequency of permanent liver damage following this infection in the pediatric age group. In older children the clinical picture and its severity becomes progressively more like that seen in adults. Expressed in another way, the severity of the disease is as a rule directly proportional to the age, ranging from mildly ill, nonjaundiced cases in infants to severely ill, jaundiced cases in older children. *Clifford G. Grulee, Jr., M.D., Infectious Hepatitis in Children. J. Louisiana M. Soc. May 1955.*

CORRESPONDENCE



Clinics for crippled children listed for November

Twenty six clinics for Illinois' physically handicapped children have been scheduled for November by the University of Illinois Division of Services for Crippled Children. The Division will count 21 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social and nursing service. There will be 4 special clinics for children with rheumatic fever and 1 for cerebral palsied children.

Clinics are held by the Division in cöoperation with local medical and health organizations, both public and private. Clinicians are selected among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or may want to receive consultative services.

The November clinics are:

November 1—Casey, High School

November 1—Pittsfield, Illini Hospital

November 2—Hinsdale, Hinsdale Sanitarium

November 3—Macomb, St. Francis Hospital

November 3—Litchfield, Madison Park School

November 3—Sterling, Field House

November 4—Chicago Heights (Rheumatic Fever), St. James Hospital

November 8—Peoria, Children's Hospital

November 8—East St. Louis, St. Mary's Hospital

November 8—Shelbyville, First Methodist Church

November 9—Joliet, Will County T.B. Sanitarium

November 10—Springfield, St. John's Hospital

November 10—DuQuoin, Marshall-Browning Hospital

November 10—Elmhurst (Rheumatic Fever), Memorial Hospital of DuPage County

November 10—Watseka, American Legion Home

November 11—Chicago Heights (Rheumatic Fever), St. James Hospital

November 15—Carmi, Carmi Township Hospital

November 15—Alton (Rheumatic Fever all day, General Orthopedic a.m.), Alton Memorial Hospital

November 16—Evergreen Park, Little Company of Mary Hospital

November 16—Springfield (Cerebral Palsy), Memorial Hospital

November 17—Rockford, St. Anthony's Hospital

November 17—Bloomington, St. Joseph's Hospital

November 18—Evanston, St. Francis Hospital

November 22—Peoria, Children's Hospital

November 22—Effingham (Rheumatic Fever), St. Anthony's Hospital

November 23—Aurora, Copley Memorial Hospital

‹ ›

Cancer lecture series

Northwestern University Medical School announces the annual series of cancer lectures will be given from October 12 to November 23 for members of the medical profession. The lec-

tures on research and present-day problems in cancer will be presented in the auditorium of the Veterans Administration Research Hospital at 333 East Huron Street, Chicago, from 5:00 to 6:00 p.m., on Wednesday evenings.

Dr. William Wartman, professor and head of the department of pathology at Northwestern University Medical School, is coordinator of the lectures.

The programs are as follows:—

October 12—The Pathology of Cancer of the Lung Correlated with Diagnosis, Treatment and Prognosis. Dr. Lauren V. Ackerman, Washington University, St. Louis, Missouri.

October 19—A Comparison of Adult, Embryonic and Cancer Tissue. Dr. Harry S. N. Greene, Yale University School of Medicine, New Haven, Connecticut.

October 26—Studies on the Mechanism of Hydrocarbon Carcinogenesis. Dr. Charles Heidelberger, University of Wisconsin, Madison, Wisconsin.

November 2—Present-Day Problems in Primary Lung Cancer. Dr. William E. Adams, University of Chicago Medical School.

November 9—Recovery From Radiation Injury. Dr. Leon C. Jacobson, University of Chicago Medical School.

November 16—Malignant Epithelial Tumors of the Extremities. Dr. Edwin A. Lawrence, Indiana University School of Medicine, Indianapolis, Indiana.

November 23—The Role of Mutation in Relation to the Origin of Tumors. Dr. Walter J. Burdette, University of Missouri School of Medicine, Columbia, Missouri.

‹ ›

University of Michigan Medical School Postgraduate Conference

The Department of Postgraduate Medicine at the University of Michigan Medical School announces the annual conference in Pediatrics, Obstetrics, and Gynecology, January 23-28, 1956, to be given at the University Hospital and the Woman's Hospital, Ann Arbor, Michigan.

Teaching Staff: Members of the Faculty of the Departments of Pediatrics, and Obstetrics and Gynecology, and the following guest speakers—

John C. Ullery, M.D., Professor of Obstetrics and Gynecology, and Chairman of the Department, Ohio State University Medical School, Columbus, Ohio.

Robert A. Kimbrough, M.D., Professor of Obstetrics and Gynecology, and Chairman of the Department, University of Pennsylvania Graduate School of Medicine.

Pediatrics: January 23 and 24

Pediatrics and Obstetrics: January 25

Obstetrics and Gynecology: January 26, 27 and 28.

Request for further information or enrollment should be addressed to:

John M. Sheldon, M.D., Director
Department of Postgraduate Medicine
Room 1610, University Hospital
Ann Arbor, Michigan

‹ ›

Annual session of Illinois Chapter, Academy of General Practice

The Eighth Annual Session of the Illinois Chapter, American Academy of General Practice will be held at the Leland Hotel, Springfield, October 25-27, 1955. The first day will be devoted principally to meetings of the Congress of Delegates, with the speaker, Robert E. Heerens, Rockford, presiding at these sessions. Dinner for delegates and their wives will be the principal evening function.

Wednesday and Thursday will see the scientific assembly in session with a well rounded program arranged for the two days. Round table luncheons are scheduled for each of these days, at 12:15 p.m.

The Annual Banquet will be conducted in the Grand Ball Room of the Leland at 7:30 p.m., Wednesday. Breaks are scheduled during the forenoon and afternoon to view the exhibits which are arranged in the same hotel. The officers of the Illinois Chapter are endeavoring to make this meeting better than those previously held, and a good attendance is expected.

‹ ›

Industrial health P. G. Courses

The Institute of Industrial Health of the University of Cincinnati announces another in its series of postgraduate courses. *Modern Considerations and Methods in Handling the Lead Problems in Industry* will be presented during

the week of November 7-11, 1955, by the Kettering Laboratory in the Department of Preventive Medicine and Industrial Health of the University of Cincinnati. The purpose of this course is to present the most recent information concerning the prevention and control of the lead problem in modern industry.

In addition to a general discussion, the course will include analytical and engineering aspects, inorganic and organic lead intoxications, and economic and legal considerations. Round table discussions will be offered. Prevention, diagnosis and treatment will be presented in detail, particularly from the point of view of the most recent information.

Physicians and industrial hygienists who are concerned with the lead problem and who are interested in attending the course should write for an application blank to Secretary, Institute of Industrial Health, Kettering Laboratory, Eden and Bethesda Avenues, Cincinnati 19, Ohio.

‹ ›

Fiske Fund Prize Dissertation 1955

The Trustees of the Fiske Fund of The Rhode Island Medical Society announce the following subject for the Prize Dissertation of 1955:

"Use of Radio-Active Isotope in the Treatment and Investigation of Disease"

For the best dissertation on this subject worthy of a premium they offer the sum of three hundred fifty dollars ($350.00). The dissertation will be particularly graded on the basis of original work by the author. Each competitor for the premium is expected to conform with the following regulations:

To forward to the secretary of the Trustees on or before the second day of February, 1956, free of all expense, a copy of his dissertation with a motto thereon, and also accompanying it a sealed envelope bearing the same motto, inscribed on the outside, with his name and address within.

Previously to receiving the premium awarded, the author of the successful dissertation must transfer to the Trustees all his right, title and interest in and to the same, for the use, benefit, and advantage of the Fiske Fund.

Dissertations, other than the successful one, will be returned to the authors.

The dissertations must be typewritten, double spaced on standard typewriter paper, and should not exceed 10,000 words.

SECRETARY to the TRUSTEES
John E. Farrell, Sc.D.
106 Francis Street
Providence 3, Rhode Island

Frank B. Cutts, M.D.
John G. Walsh, M.D.
Charles L. Farrell, M.D.
TRUSTEES

‹ ›

Medical reservists to earn credit points at military surgeons meeting

Reserve credit points may be earned by Medical Service reservists on inactive duty for attending daily sessions of the forthcoming 62d Annual meeting of the Association of Military Surgeons, the Department of Defense announced recently.

This authorization covers eligible physicians, dentists, veterinarians, nurses, women's medical specialists, and Medical Service Corps officers of the U. S. Army, Navy, and Air Force Reserves.

The unprecedented three-day meeting will include comprehensive discussions of the medical problems facing the military services and the nation in an atomic war and will be held on November 7, 8, and 9, at the Hotel Statler in Washington, D. C.

Point credits will be awarded to eligible reservists on the basis of one point for each day of attendance. According to Col. Cyrus H. Maxwell, MC, USAR, Chairman of the Association's Committee for Reserve Officers, a special booth will be set up for each day's registration. Authenticated reports of attendance will be sent later to the respective headquarters of each service to assure creditation.

Representatives of the responsible sections dealing with reserve affairs in four services, United States Public Health Service, Army, Navy and Air Force, will be available on appointment for conferences with individual reserve officers.

‹ ‹ ‹ › › ›

NEWS of the STATE



COOK

Personal.—Dr. Ben L. Boynton was elected president of the American Academy of Physical Medicine and Rehabilitation, September 2.

New Officers of German Society.—Dr. Eugene F. Lutterbeck was chosen president of the German Medical Society of Chicago recently. Other officers are Dr. Gustav L. Zechel, Vice-President; Dr. Lydia Walkowiak, Secretary; and Dr. Joseph R. Mueller, treasurer.

The Mayo Memorial Lectures.—E. Dahl-Iversen, professor of surgery at the University of Copenhagen, Denmark, will deliver the Charles H. Mayo memorial lectures at Northwestern University Medical School, October 26, on the Functions of the Endocrine Organs During the Postoperative Period. Professor Dahl-Iversen, well known for his surgical work in the field of endocrine glands is also chief of surgical services of the University Surgical Clinic at Rigshospitalet, Copenhagen. The lectureships on surgery were founded by Dr. Charles H. Mayo, founder of the Mayo Clinic, who graduated at Northwestern University medical school in 1888. The first lecture was given in 1931.

New Courses at University of Chicago.—Courses in two new specialized fields created by the atom age, health physics and radiological physics will be offered by the University of Chicago this fall. According to a news release, hazards in the rapidly expanding use of radiation sources, such as reactors and accelerators, and materials such as radioisotopes, have created a demand for trained health physicists that can not now be met.

The new courses, both two-year programs leading to the master's degree, are the first to be offered by a non-governmental agency, the University announced. The only training in the fields so far has been by the Atomic Energy Commission, which instituted courses in Oak Ridge, Tennessee, primarily to meet its own needs for the new kind of specialists.

A pioneer in the field of nuclear energy and radioactivity in both theoretical investigation and in medical use, the university has exceptional facilities for training in the two fields. Its Research Institutes have a battery of radiation creating machines ranging from its 450-million volt synchrocyclotron to linear accelerators, betatrons, and other specialized devices.

The Argonne Cancer Research Hospital, built on the Midway by the AEC, and operated for it by the University, is the only hospital specially designed for the medical use of all radioactive sources in investigation and treatment. Its unique features include not only the high radiation sources, but an isotope pharmacy, special disposal provisions for radiation-contaminated material and products, and other facilities with which the health physicist must be familiar.

Both the new courses will be given in the department of radiology of the University's medical center, under the supervision of Lester S. Skaggs, associate professor of medical physics. Physicists, biologists, and doctors will participate in the instruction. During the second year of the courses, students will be employed half-time in either the University's Health Physics Service or in the department of radiology.

Morton Medical Research Building Dedicated.—On September 27, the official dedication ceremony took place for the new seven story Morton Medical Research Building on the Northwestern University Chicago campus. Mr. Sterling Morton, chairman of the board of the Morton Salt Company, spoke at the ceremony. He is the son of Mr. Joy Morton, Chicago financier and founder of the Morton Salt Company, in whose memory his widow, Mrs. Margaret Gray Morton, left a bequest of two million dollars to construct the building.

The new structure, connected to the Montgomery Ward building, which houses the medical and dental schools, is of modified Gothic architecture similar to the Ward building and is faced with Indiana limestone.

A special feature is the movable metal wall partition, equipped with water, gas, steam, air, and vacuum pipes. These can be set up at any 10-foot interval within the building and will allow speedy conversion of laboratories to almost any size desired.

The department of surgery will conduct its research on the top floor of the Morton building, a floor connected with a related department, the department of anatomy, in the Ward building. On the fifth and sixth floors the departments of pharmacology and obstetrics and gynecology are connected to the department of physiology and bacteriology in the Ward building.

Located on the third and fourth floors of the Morton building is the department of medicine, while those floors in the Ward building house, in addition to other sections, the department of biochemistry and some of the Montgomery Ward clinics.

On the second floor, opposite others of the Ward clinics, are the departments of radiology, urology, and orthopedic surgery and a special radioisotope laboratory. The first floor of the Morton building has facilities for the department of neurology and psychiatry and for clinical art and photography.

University News.—Dr. Harold Shellow has been appointed clinical associate professor of dermatology at the University of Illniois College of Medicine. He has been a member of the faculty for 25 years. The Chicago Medical School has been awarded a research grant of $7,035 by the Schering Corporation for investigative work in the field of rheumatoid arthritis. The work will be carried out under the direction of Dr. Ben B. Blivaiss, assistant professor of physiology, and Edward F. Rosenberg, assistant professor of medicine, together with associates. They will study the relation of the pituitary-ovary axis to the production and utilization of adrenal cortex hormones.

Memorial to Ludwig Hektoen.—Dr. Esmond Long, Director of the Henry Phipps Institute of the University of Pennsylvania, will deliver the Richard H. Jaffee Lecture of the Institute of Medicine of Chicago, November 14, 1955. The lecture will be presented at a joint meeting of the Institute of Medicine, the Chicago Pathological Society and the Society of Medical History of Chicago. The meeting will be devoted to a memorial to the late Dr. Ludwig Hektoen.

Michael Reese Dedicates New Building.—The new one and a quarter million dollar building of the Michael Reese Research Foundation was officially dedicated, September 11, in honor of the late Dr. Sidney O. Levinson, first executive director of the foundation. The two story reinforced concrete structure is on a site cleared of slum dwellings by the Chicago Housing Authority for the Michael Reese Medical Center. It contains facilities for blood donors, a large blood bank, extensive laboratories for preparation of plasma and serums required for community service, and research laboratories and offices.

The Hektoen Institute for Medical Research of the Cook County Hospital announced the second Dr. Ludvig Hektoen Memorial Lecture, delivered by Professor Herwig Hamperl, Director of the Pathological Institute of the University of Bonn, Germany on Nutrition and Disease.

The lecture was delivered on October 12 at 8:00 p.m. in the amphitheatre of the Department of Pathology of Cook County Hospital, 1825 West Polk Street, Chicago.

LAKE

Physician Honored.—Dr. Theodore S. Proxmire, now in his fiftieth year of practice in Lake Forest, was honored August 3, at the annual Lake Forest day which he originated in 1909, newspapers report. Dr. Proxmire's service to the community was the theme of floats in a parade which ended in Lake Forest's West park. Several hundred persons, at whose births he officiated, released balloons in a program in the park. The Lake Forest Woman's club presented $500 to him which he turned over to the Multiple Sclerosis foundation.

Highland Park Hospital Chosen for Hemoglobin Study.—The Highland Park Hospital has been chosen one of 125 hospitals in the United States, Canada, and England to participate in research on standardizing the testing the hemoglobin, the Chicago Tribune reported September 8. According to the report, Dr. Gerald S. Dean, pathologist in charge of the Highland Park program, said many different methods of measuring hemoglobin are used in the world's hospitals. "If a uniform hemoglobin standard were made available to all hospitals, and a single method practiced, the individual laboratory would then have assurance not only that its results would be comparable from month to month, but that they also would be comparable with those of other laboratories employing the same standard," the report stated.

ST. CLAIR

Society News.—Dr. Peter G. Danis, chairman of the department of pediatrics at St. Louis University School of Medicine, St. Louis, addressed the St. Clair County Medical Society, September 1, on "The Problem of Chronic Illness in the Child."

SANGAMON

Society Election.—At the recent annual business meeting of the Sangamon County Medical Society in Springfield, Dr. E. F. Pearson was chosen president; Dr. A. E. Steer was named vice-president and Dr. William DeHollander, secretary-treasurer. Drs. Franz K. Fleischli and Thomas F. Harmon were named to the board of directors for a three year term and Drs. Darrell Trumpe and Kenneth Schnepp were named delegates to the Illinois State

Medical Society. Alternate delegates are Drs. Harmon and J. Marvin Salzman.

Staff Chooses New Officers.—Dr. Herbert B. Henkel, Sr. was re-elected president of the staff of St. John's Hospital at the annual meeting in Springfield recently. Dr. Jacob E. Reisch was named vice-president and Dr. A. Elon Steer, secretary. Chairmen of the various sections are Drs. Frank M. Davis, surgery; Thomas D. Masters, medicine; A. R. Eveloff, pediatrics; William W. Curtis, obstetrics; Paul LaFata, general practice; William DeHollander, radiology, and David O. Holman, pathology. Dr. Harold D. Palmer recently was appointed to the staff of St. John's in the department of pathology.

Society News.—Dr. Albert E. Rauh addressed the Sangamon County Medical Society at the Elks Club, September 1, on "Clinical Aspects of Electroe Cephalography".

VERMILION

Fifty Year Club Members.—Dr. Herscehle Baldwin, Danville, Dr. Jessie M. James of Henning and Dr. Otto E. Fink, Kankakee, were presented with the Fifty Year Club pins and certificates of the Fifty Year Club of the Illinois State Medical Society at a meeting of the Vermilion County Medical Society recently. Dr. Harlan English, Councilor for the Eighth District, made the presentation.

Programs of Society.—Dr. Elmer Hess, Erie, Pennsylvania, President of the American Medical Association, will address the Vermilion County Medical Society, November 1, at a meeting in the Hotel Wolford in Danville. His subject will be the "General Practitioner as a Urologist." Other fall meetings were September 6, Dr. Aldo A. Luisada spoke on "Acute Pulmonary Edema." On October 4, Dr. John A. Campbell, professor and chairman of the Department of Radiology, Indiana University School of Medicine, spoke on "Clinical Uses of Radio-Isotopes.

GENERAL

Health Officer Named.—Dr. Peter C. Supan has been appointed health officer by the Boards of Health of Shelby and Effingham counties, according to the Illinois Health Messenger.

"Medical Report" Title of New TV Series on WTTW, Channel 11.—On September 23, 1955, at 9:30 p.m. the **Educational Committee** of the **Illinois State Medical Society** presented **Medical Report"** on **WTTW, Channel 11,** the new educational station in Chicago. The subject was "Ulcers of the Stomach". Participants were **George M. Cummins, M.D.,** associate in medicine, Northwestern University Medical School, and **Theodore R. Van Dellen, M.D.,** Medical Editor of the Chicago Tribune. This was a preview program in the regular series to be presented by the **Educational Committee** on WTTW, beginning December 2, 1955, in the permanent studios in the Museum of Science and Industry.

"Your Doctor Speaks" on FM Station WFJL.—The following physicians have recently appeared in transcribed broadcasts over **FM Station WFJL** on Thursday evenings at **7:45 p.m.** The series is presented by the **Educational Committee** of the **Illinois State Medical Society:**

J. Henry Heinen, Jr., department of orthopedics, Evangelical Hospital, August 18, on Your Child's Feet.

Arthur DeBoer, assistant attending surgeon, Children's Memorial Hospital, August 25, on Care of Hernias in Infants and Children.

G. Kenneth Lewis, clinical associate professor of otolaryngology, University of Illinois College of Medicine, September 1, on Plastic and Reconstructive Surgery.

Robert G. Thompson, department of orthopedic surgery, Chicago Wesley Memorial Hospital, September 1, on Amputations and Modern Prosthetics.

Palmer Good, Oak Park, associate attending ophthalmologist, Children's Memorial Hospital, September 15, on Eye Problems in Adolescents.

George Milles, director of the laboratory, Augustana Hospital, September 22, on What Is a Tumor?

"All About Baby" on WGN-TV, Channel 9.—The following physicians have appeared on the telecast **"All About Baby"** on **WGN-TV, Channel 9,** under the auspices of the **Educational Committee** of the **Illinois State Medical Society:**

Eugene T. McEnery, associate clinical professor of pediatrics at Stritch School of Medicine of Loyola University, August 31, on Common Behavior Problems.

John L. Reichert, member of the attending staff, Children's Memorial Hospital, September 7, on The Child Who Won't Eat.

Jack A. Weiss, associate professor of otolaryngology, Chicago Medical School, September 14, on Ear, Nose and Throat Infections.

Lowell F. Peterson, associate attending physician at Presbyterian Hospital, **September 21,** on The Doctor Discusses Pregnancy.

Lectures Arranged Through the Educational Committee of the **Illinois State Medical Society:**

Joseph Rappaport, Evanston, Washington School PTA in Waukegan, September 27, on Problems of Parenthood.

Morris T. Friedell, Maine Township Adult Evening School in Des Plaines, October 17, on Cancer.

John W. Payne, La Grange, Maine Township Adult Evening School, October 24, on The Menopause.

John B. Hall, Director of the Cook County Department of Health, Kellogg School PTA, October 17, on Present Status of the Salk Vaccine.

H. Paul Carstens, Oak Park, Young Married Couples Sunday Evening Club, October 23, on New Developments in Medicine.

Frank E. Doyle, Jesse Spaulding School, PTA, November 8, on Sex Education—A Family Affair.

Alfred D. Biggs, Marquette School PTA, Novem-

ber 15, on Problems of the School Child.

Lectures Arranged Through the Scientific Service Committee of the **Illinois State Medical Society:**

Joseph T. O'Neill, Ottawa, Lee-Whiteside County Medical Societies in Dixon, September 15, on What Your Society Means to You.

I. Keith Neece, Decatur, Montgomery-Macoupin County Medical Societies in Litchfield, October 19, on Genito-Urinary Infections in Children.

Louis R. Limarzi, Stock Yards Branch of the Chicago Medical Society at Evangelical Hospital, November 18, on What's New in Blood Treatment.

Paul S. Rhoads, Chicago, Henry County Medical Society in Kewanee, November 9, on Use of Antibiotics.

Max S. Sadove, Chicago, La Salle County Medical Society at the Pines Restaurant, Streator, November 10, on Pre and Postoperative Therapy.

William R. Best, Chicago, Knox County Medical Society in Galesburg, November 17, on Blood Disorders.

DEATHS

Wilford Aldrich Danielson*, Chicago, who graduated at the Chicago College of Medicine and Surgery in 1915, died June 29, aged 64, of cerebral hemorrhage, hypertension, and cancer of the prostate.

Robert W. Edwards*, LaGrange, who graduated at the University of Illinois College of Medicine in 1926, died August 10, aged 56. He was a member of the staff of West Suburban Hospital, Oak Park, MacNeal Memorial Hospital, Berwyn, and the Hinsdale Sanitarium and Hospital.

John Henry Gaff*, Chicago, who graduated at St. Louis College of Physicians and Surgeons in 1907, died April 9, aged 73.

George Ray Hill*, Rochelle, formerly of Fairfield, who graduated at the University of Illinois College of Medicine in 1936, died June 11, aged 44. He had served during World War II.

George Frederick Johnson*, formerly of East Moline, who graduated at St. Louis College of Physicians and Surgeons in 1896, died in Montalvo, California, August 6, aged 82. He was a member of the "Fifty Year Club" of the Illinois State Medical Society.

William Brown McDonald*, Dixon, who graduated at Hering Medical College in 1910, died June 8, aged 90, of arteriosclerotic heart disease.

Naif E. Nassar*, Chicago, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois in 1909, died August 24, aged 68.

Harry V. Prescott*, Dallas City, who graduated at the College of Physicians and Surgeons of Chicago in 1893 and at the University of Pennsylvania School of Medicine in 1896, died August 8, aged 88. He was a member of the "Fifty Year Club" of the Illinois State Medical Society.

John Charles Roberts*, Peoria, who graduated at the College of Physicians and Surgeons of Chicago in 1887, died June 19, aged 93, of glomerulonephritis and arteriosclerosis. He was an honorary member of the staff of Proctor Hospital.

Ben Druze Senturia*, Chicago, who graduated at Washington University School of Medicine, St. Louis, in 1923, died July 18, aged 56, of coronary occlusion. He had served during World War II and was a member of the staff of the Veterans Administration Hospital.

Mary Ellen Sharkey, Chicago, who graduated at Jenner Medical College in 1908, died in the Bethany Hospital, July 2, aged 79, of arteriosclerosis.

*Indicates member of Illinois State Medical Society.

for

quality simplicity economy

in Infant Feeding

BAKER'S MODIFIED MILK

quality—Made from Grade A Milk (U. S. Public Health Service Milk Code) assuring maximum purity and cleanliness.

simplicity—Merely dilute Baker's (liquid form) with an equal amount of water, previously boiled.

economy—Contains adequate amounts of all known essential vitamins. Expensive supplemental vitamins need not be prescribed.

Baker's Modified Milk is supplied gratis to all hospitals.



Baker's Modified Milk is available in both powder and liquid forms.

FEEDING DIRECTIONS (Liquid)		
	Baker's	Boiled Water
First 5 days of life	1 part	2 parts
Second 5 days	1 part	1½ parts
After 10th day	1 part	1 part

Powder—Normal dilution one tablespoon to 2 ounces of water.

THE BAKER LABORATORIES, INC.

Milk Products Exclusively for the Medical Profession

Main Office: **Cleveland 3, Ohio** • ***Plant:*** **East Troy, Wisconsin**

BOOK REVIEWS



THE PHYSIOLOGICAL BASIS OF MEDICAL PRACTICE By Charles Herbert Best C.B.E., M.A., M.D., D.Sc (Lond.) F.R.S., F.R.C.P. Professor and Head of Department of Physiology, Director of the Banting-Best Department of Medical Research, University of Toronto. And Norman Burke Taylor V.S., M.D., F.R.S. (Canada), F.R.C.S. (Edin.), F.R.C.P. M.R.C.S. (Eng.), L.R.C.R. (Lon.) Professor of the History of Medicine and Medical Literature, University of Western Ontario, London, Canada; formerly Professor of Physiology, University of Toronto. Published by The Williams & Wilkins Company Baltimore.

Copyright 1955 Price $12.00

This text is now in its Sixth Edition. Since first published in 1937 it has gained a special place for itself in the armamentarium of every medical student struggling through his first year of medical school. It is of course fundamentally a textbook for medical students, but is also of great value as a reference book among those in private practice.

Since the last edition published five years ago, there has been an extensive revision of almost every chapter.

The great studies which have been made in ACTH and Cortisone research are adequately covered, to give but one example of the revisions embodied in this latest edition.

There is a very large and extensive bibliography. As usual the photographies, charts, diagrams, tables and line drawings are satisfactory and arranged with logic and considerable teaching impact.

CURRENT THERAPY 1955 By Howard F. Conn, M.D. Consulting Editors: M. Edward Davis; Vincent J. Derbes; Garfield G. Duncan; Hugh J. Jewett; William J. Kerr; Perrin H.; H. Houston Merritt; Paul A. O'Leary; Walter L. Palmer; Hobart A. Reimann; Cyrus C. Sturgis; Robert H. Williams. Published by W. B. Saunders Company, Philadelphia & London.

Copyright 1955 Price $11.00

Because this textbook covers so well the field of general medicine concisely, practically, and systematically, it is no small wonder this 7th edition is eagerly awaited by many busy general practitioners.

Pursuant of its very nature, certain sections and topics have remained unchanged from last years edition. However, almost every new and improved method of Therapeutics developed in the past year has been incorporated in this latest work.

This is a huge volume of almost 700 pages, divided into sixteen sections and a veritable host of qualified contributors. The management of each disease state is logically developed. When deemed necessary the therapeutic regimen of more than one physician is presented. A drug roster, a table of metric and apothecaries' systems and tables for making percentage solutions are included toward the back of the book. The index, printing paper and binding are satisfactory.

‹ ›

PSYCHIATRY FOR THE FAMILY PHYSICIAN By C. Knight Aldrich, M.D. Associate

(*Continued on page* 60)

When obesity is an expression of mental and emotional distress...

'Dexamyl' can often be of value in the treatment of the overweight patient who tends to relieve the poverty of his emotional state by the richness of his diet. A balanced combination of Dexedrine* Sulfate and amobarbital, 'Dexamyl' curbs the appetite and lessens the emotional tension that causes overeating and *overweight.*

DEXAMYL*

tablets—elixir
Spansule† capsules

to control the factors that cause overeating



Each 'Dexamyl' Tablet or teaspoonful (5 cc.) of the Elixir contains: 'Dexedrine' Sulfate (dextro-amphetamine sulfate, S.K.F.), 5 mg., and amobarbital, ½ gr.

Also Available: 'Dexamyl' *Spansule* (No. 1), slowly releasing the equivalent of *two* tablets; 'Dexamyl' *Spansule* (No. 2), slowly releasing the equivalent of *three* tablets.

Smith, Kline & French Laboratories, Philadelphia

*T.M. Reg. U.S. Pat. Off.
†T.M. Reg. U.S. Pat. Off. for S.K.F.'s brand of sustained release capsules.
Patent Applied For.



The pleasant cinnamon flavor of this children's sulfa tablet carries clear through—no bitter after-taste. Children will accept your therapy gladly because Demisulf can be chewed or will disintegrate rapidly in a teaspoonful of water.

Doctors have found Demisulf most successful for treating their young patients with a well balanced sulfa combination.

Sulfadiazine	*0.083 Gm.*
Sulfamerazine	*0.083 Gm.*
Sulfamethazine	*0.083 Gm.*
(Represents Total Sulfonamides	*0.250 Gm.)*

Try Demisulf for your next young patient. Send for your free testing sample today.

Please send me my testing sample of Demisulf along with complete information.

Name_____

Street_____

City_____ Zone____ State_____

YATES DRUG COMPANY

295-303 Lafayette Street, New York 12, N. Y.

BOOK REVIEWS (Continued)

Professor of Psychiatry, University of Minnesota Medical School. Published by The Blakiston Division, McGraw-Hill Book Company, Inc. New York, Toronto, London.

Copyright 1955 Price $5.75

This is an extremely practical book. The family physician is usually the first professional man to see the patient with emotional problems. He is familiar with his family, business, social and educational background. This text attempts to intelligently synthesize this vast fund of knowledge so that the family physician can initiate the treatment of emotional problems of all his patients. With the insight gained through this rich knowledge of his patients background, the family physician can oftimes prevent the development of many future potentially serious emotional problems and through early recognition of the more serious problems guide his patient into the hands of a specialist in the field.

This text is not burdened with detailed complicated psychiatric theories, but is eminently practical.

‹ ›

PAIN, ITS MECHANISMS AND NEUROSURGICAL CONTROL by James C. White, M.D., F.A.C.S. Chief of Neurosurgical Service, Massachusetts General Hospital, Associate Professor of Surgery, Harvard Medical School and William H. Sweet, M.D., F.A.C.S. Associate Visiting Neurosurgeon, Massachusetts General Hospital, Associate Clinical Professor of Surgery, Harvard Med. School. Published by Charles C. Thomas, Springfield, Illinois.

Copyright 1955 Price $17.50

This is a very detailed comprehensive monograph for those who are interested in the relief of intractable pain for which there is no possibility of eliminating the underlying cause. It is so technical and highly specialized that only neuro surgeons will be able to obtain the maximum benefit through ownership. However, it will serve as a valuable reference work for students and those actively engaged in the practice of medicine.

The text is profusely illustrated throughout with excellent line drawings and photographs. The clear type and gloss paper make for easy reading.

(*Continued on page* 62)

DESPITE PRESENCE OF MUCINOUS MATERIAL AND BLOOD SERUM

ALL TRICHOMONADS

ARE DESTROYED IN 30 SECONDS![1]

The new trichomonacide, VAGISEC* jelly and liquid, clears up even stubborn clinical cases of vaginal trichomoniasis. Used with the Davis technic, it penetrates to hidden trichomonads—ends treatment failure and flare-ups.



VAGISEC liquid penetrates to trichomonads buried among the vaginal rugae and imbedded in mucus and desquamated cells.

Trichomonads explode within seconds. "Motion pictures taken through a phase-contrast microscope at 24 frames per second, show that most trichomonads are destroyed within ten seconds after contact with a 1:250 solution. . . . Even in the presence of blood serum and mucinous material all are destroyed within 30 seconds."[1]

Explosion succeeds. ". . . over 90% of apparent cures have been obtained . . ."[1] with VAGISEC liquid. This preparation "has proved in vitro to be over ten times as effective in killing T. vaginalis, when compared with any of the douche powders available through the drug trade."[1] VAGISEC jelly stays in the vagina to destroy trichomonads at night.

Why they explode. Three chemical components of VAGISEC liquid attack the trichomonad synergistically. A chelating agent complexes and takes away the calcium of the calcium proteinate. A wetting agent removes lipid materials. A detergent denatures the protein. The parasite imbibes water, swells up and explodes.

The Davis technic.† Dr. Carl Henry Davis, well-known gynecologist and author, and C. B. Grand, research physiologist, introduced this new trichomonacide as "Carlendacide." Over one hundred leaders in obstetrics and gynecology tested it clinically and found it a remarkably fast-acting, effective therapy. Doctor Davis recommends a combination of 1) VAGISEC liquid in office treatment; 2) home treatment with VAGISEC jelly at night and 3) douche with VAGISEC liquid in the morning. "A few women have infected cervical, vestibular or urethral glands and require other types of treatment . . ."[1]

VAGISEC jelly and liquid are non-toxic and non-irritating. In a recent collected study only about one per cent of women showed evidence of allergy to VAGISEC liquid.[1]

Office Treatment. Expose vagina with speculum. Wipe walls dry with cotton sponges and wash thoroughly for about three minutes with a 1:250 dilution of VAGISEC liquid. Remove excess fluid with cotton sponges. Dr. Davis recommends six office treatments.

Home Treatment. Patient inserts VAGISEC jelly each night and douches with VAGISEC liquid (2 teaspoonfuls in 2 quarts of warm water) each morning except on office treatment days. Continued douching two or three times a week helps to prevent re-infection. Pregnant women should have office treatments only.

Summary. The unique synergistic action of VAGISEC liquid explodes both hidden and surface vaginal trichomonads. This therapy has a high apparent cure rate and results in fewer flare-ups. VAGISEC jelly and liquid are non-toxic and non-irritating, and leave no messy discharge or staining.

1. Davis, C. H.: West. J. Surg. 63:53 (Feb.) 1955.

*VAGISEC IS THE TRADE-MARK OF JULIUS SCHMID, INC. †PAT. APP. FOR

JULIUS SCHMID, INC., *gynecological division*
423 West 55th Street, New York 19, N. Y.

Active ingredients: Polyoxyethylene nonyl phenol, Sodium ethylene diamine tetra-acetate, Sodium dioctyl sulfosuccinate. In addition, VAGISEC jelly contains Boric acid, Alcohol 5% by weight.



BOOK REVIEWS (Continued)

An added feature is incorporated in Chapters Four and Ten where considerable space is alloted to the psychological aspects of pain and an evaluation of the functional overlay which may obtain in all types of organic pain.

‹ ›

PEDIATRIC DIAGNOSIS By Morris Green, M.D., Assistant Professor of Pediatrics, Yale University School of Medicine. Julius B. Richmond, M.D., Professor and Chairman of the Department of Pediatrics, State University of New York College of Medicine at Syracuse. Published by W. B. Saunders Company, Philadelphia, London.

Copyright 1954 Price $10.00

Here is a very comprehensive text of great value to both the pediatrician and student alike. The material is well organized and logically arranged. An added feature oftimes overlooked in textbooks is the inclusion of the bibliography with the pertinent subject material instead of listing them at the close of the chapter.

The introductory chapter is devoted to the importance of a detailed accurate pediatric history. Subsequent chapters enumerate comprehensive examination of the head, eyes, ears, nose and on through the various systems in a most meticulous manner. The latter half of the text is concerned with a thorough evaluation of the common pediatric symptoms, such as diarrhea, pallor, anorexia, nausea, or vomiting.

The appendix contains detailed charts for percentiles for weight and length chronologically arranged.

It was thought by this reviewer that perhaps more emphasis and diagnostic suggestions for early detection of malignancies would have greatly strengthened an already excellent text.

J.W.P.

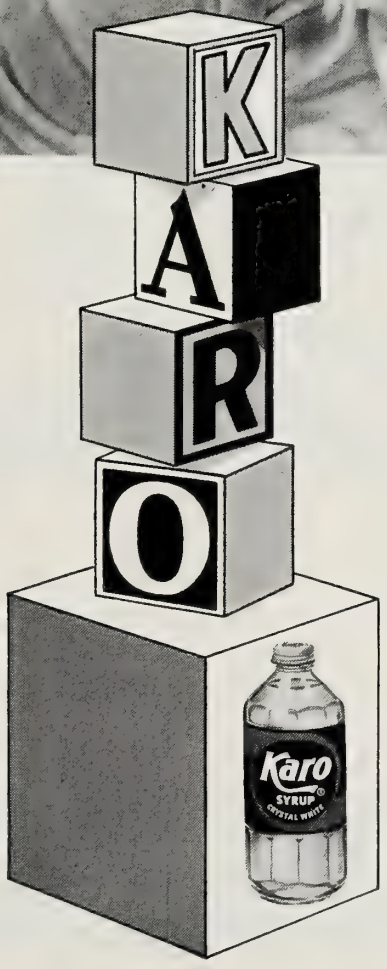
BOOKS RECEIVED

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

OLD AGE IN THE MODERN WORLD: Report of the Third Congress of the International Association of Gerontology; London, 1954. E. & S. Livingstone, Ltd., Edinburgh and London. The Williams & Wilkins

(*Continued on page* 64)





The individualized formula is the foundation of the infant's health and future development

For 3 generations KARO has been the foundation of the individualized formula

Karo is well tolerated, easily digested, gradually absorbed at spaced intervals and completely utilized. It is a balanced fluid mixture of maltose, dextrins and dextrose readily soluble in fluid whole or evaporated milk. *Precludes* fermentation and irritation. Produces no intestinal reactions. Is hypo-allergenic. Bacteria-free Karo is safe for feeding prematures, newborns, and infants—well and sick.

Light and dark Karo are interchangeable in formulas; both yield 60 calories per tablespoon.

CORN PRODUCTS REFINING COMPANY
17 Battery Place, New York 4, N. Y.

BOOKS RECEIVED (Continued)

Company, Baltimore, Maryland. Price $8.00.

LECTURES ON THE SCIENTIFIC BASIS OF MEDICINE. Volume III; 1953-1954. British Postgraduate Medical Federation. Published, New York: August 1, 1955; John de Graff, Inc. Price $6.00.

COUNSELING IN MEDICAL GENETICS: By Sheldon C. Reed, Director of Dwight Institute for Human Genetics, The University of Minnesota. 268 pages. Publication date August 3, 1955. W. B. Saunders Company, Philadelphia and London. Price $4.00.

CLINICAL PATHOLOGIC CONFERENCES OF COOK COUNTY HOSPITAL. Volume I. Cardiovascular-Renal Problems. Edited by Hans Popper, M.D., Ph.D., Director, Department of Pathology, Cook County Hospital, and Daniel S. Kushner, M.D., Associate Director of Medical Education, Cook County Hospital. The Blakiston Company, Inc., New York and Toronto. Price $5.00.

FRACTURES AND JOINT INJURIES: By Sir Reginald Watson-Jones, FRCS., etc., Extra Orthopaedic Surgeon to Her Majesty, the Queen; Orthopaedic Surgeon to His Late Majesty, King George VI; Director, Orthopaedic and Accident Service, London Hospital; etc., Volume II, Fourth Edition. Williams & Wilkins Company, 1955. Price $22.00 for two volumes.

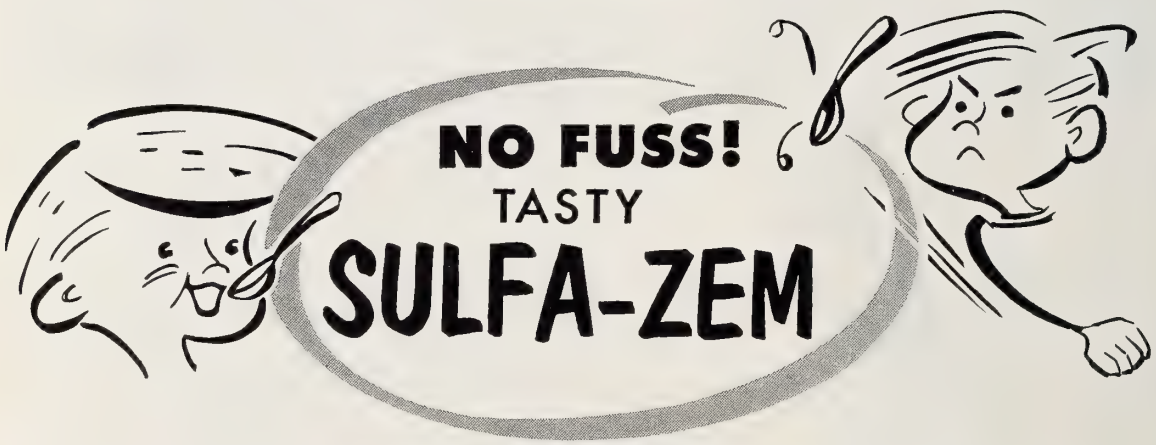
SYSTEMIC LUPUS ERYTHEMATOSUS: Review of the Literature and Clinical Analysis of 138 Cases. By A. McGehee Harvey, M.D., Lawrence E. Shulman, M.D., Philip A. Tumulty, M.D., C. Lockard Conley, M.D., Edyth H. Schoenrich, M.D., From the Department of Medicine of the Johns Hopkins University and Hospital. Williams & Wilkins Company, 1955. Price $3.00.

THE MECHANISMS OF HEALING IN HUMAN WOUNDS: A Correlation of the Clinical and Tissue Factors involved in the Healing of Human Surgical Wounds, Burns, Ulcers, and Donor Sites: By Shattuck W. Hartwell, M.D., Chief of Surgery, Mercy Hospital, Muskegon, Michigan. Charles C. Thomas, Publisher, Springfield, Illinois. Price $4.75.

PEPTIC ULCER; Diagnosis and Treatment; By Clifford J. Barborka, M.D., Associate Professor of Medicine and Chief, Gastrointestinal Clinics, Northwestern University Medical School, and E. Clinton Texter, Jr., M.D., Associate in Medicine, and Assistant Chief, Gastrointestinal Clinics, Northwestern University Medical School. with 33 Illustrations. Little Brown and Company, Boston, Toronto. Price $7.00.

EXPERIMENTAL PSYCHOLOGY. A Series of Broadcast Talks on Recent Research by A. J. Watson, Harry Kay, J. A. Deutsch, B. A. Farrell, Michael Argyle

(*Continued on page* 66)



Children enjoy taking delicious liquid Sulfa-Zem. Ideal also for those who have difficulty swallowing tablets. The multiple formula offers greatest potency against the greatest number of infections. Sulfa-Zem maintains high blood levels and excellent tissue distribution. Use of only a fractional dosage of 4 different sulfas absolutely minimizes undesirable side effects.

Each teaspoonful (5cc.) contains:

Sulfadiazine	2½ gr. (0.15 Gm.)
Sulfamerazine	2½ gr. (0.15 Gm.)
Sulfamethazine	1½ gr. (0.1 Gm.)
Sodium Sulfacetamide	1 gr. (60 mg.)

16 oz. and 3 oz. bottles.

THE ZEMMER CO.
3943 Sennott St. Pittsburgh 13, Pa.

Pyridium®

(PHENYLAZO-DIAMINO-PYRIDINE HCl)

Gratifying relief from urinary distress in a matter of minutes

IMPORTANT BENEFITS: Well-tolerated, fast-acting urinary analgesic. Action confined to GU tract. Compatible with sulfas and antibiotics.



EFFECTIVE—In a clinical report covering 118 cases of pyelonephritis, cystitis, prostatitis and urethritis,[1] PYRIDIUM relieved or abolished pain and burning in 93% of the patients and decreased or eliminated nocturia in 83.7% of the cases.

NONTOXIC—Analgesia from PYRIDIUM is restricted to the urogenital mucosa. Concomitant administration of PYRIDIUM and sulfonamides or antibiotics is often desirable to relieve pain in the interval before the antibacterials can act.

PHYSIOLOGICAL—Through its local analgesic action, PYRIDIUM helps relax the sphincters, thus facilitating emptying of the bladder.

PSYCHOLOGICAL—The characteristic orange-red color of PYRIDIUM in the urine is often an immediate assurance to the patient of prompt action.

SUPPLIED—in 0.1 Gm. (1½ gr.) tablets, vials of 12 and bottles of 50, 500, and 1,000.

PYRIDIUM *is the registered trade-mark of Nepera Chemical Co., Inc., for its brand of phenylazo-diamino-pyridine HCl. Sharp & Dohme, Division of Merck & Co., Inc., sole distributor in the United States.*

SHARP & DOHME

PHILADELPHIA 1, PA.

DIVISION OF MERCK & CO., INC.

REFERENCE: 1. Kirwin, T. J., Lowsley, O. S., and Menning, J., Am. J. Surg. **62**:330-335, December 1943.

BOOK REVIEWS (Continued)

and R. C. Oldfield. Philosophical Library, New York. Price $2.75.

SALIVARY GLAND TUMORS: By Donald E. Ross, M.D., Diplomate, The American Board of Surgery, Chief Surgeon, Ross-Loos Medical Group, Los Angeles, California. Charles C. Thomas, Publisher, Springfield, Illinois. Price $7.50.

NEW AGE DETERMINATIONS BY THE LEAD METHOD; Annals of the New York Academy of Sciences: Volume 60, Art. 3, Pages 509-520. Editor, Roy Waldo Miner. By J. Laurence Kulp, George L. Bate, and Bruno J. Giletti. Published by the Academy, December 1954. 50c.

A GENERAL THEORY OF ASSOCIATION. Annals of the New York Academy of Sciences. Volume 60, Art. 4, Pages 521-540. Editor, Roy Waldo Miner. By Robert Ginell. Published by the Academy, April 1955. 75c.

RECENT ADVANCES IN THE STUDY OF THE STRUCTURE, COMPOSITION AND GROWTH OF MINERALIZED TISSUES. Annals of the New York Academy of Sciences. Volume 60, Art. 5. Pages 541-806. Editor, Roy Waldo Miner. Roy O. Greep and Albert E. Sobel, Conference Co-Chairmen. Published by the Academy, April 1955. $4.00.

INSTRUMENTATION. Annals of the New York Academy of Sciences. Volume 60, Art. 6, Pages 807-964. Editor, Roy Waldo Miner. Joseph Greenspan, Conference Chairman. Published by the Academy, April 1955, $3.00.

MOLECULAR EVENTS IN DIFFERENTIATION RELATED TO SPECIFICITY OF CELL TYPE. Annals of the New York Academy of Sciences. Volume 60, Art. 7. Pages 965-1160. Editor, Roy Waldo Miner. By H. Clark Dalton, Conference Chairman. Published by the Academy, June 1955. $3.50.

HYDROCORTISONE, ITS NEWER ANALOGS AND ALDOSTERONE AS THERAPEUTIC AGENTS. Annals of the New York Academy of Sciences. Volume 61, Art 2, Pages 281-636. Editor, Roy Waldo Miner. By Joseph W. Jailer, Conference Chairman. Published by the Academy, May 1955. $4.50.

BIOFLAVONOIDS AND THE CAPILLARY. Annals of the New York Academy of Sciences. Volume 61, Art. 3. Pages 637-736. Editor, Roy Waldo Miner. By Gustav J. Martin and Albert Szent-Gyorgyi. Published by the Academy, 1955. $3.00.

A TEXTBOOK OF MEDICINE. Edited by: Russell L. Cecil, M. D., Sc. D., Professor of Clinical Medicine Emeritus, Cornell University, New York and Robert F. Loeb, M. D., Sc. D., D. Hon. Causa, LL. D., Bard Professor of Medicine, Columbia University, New York. Associate Editors: Alexander B. Gutman, M. D., Ph. D., Professor of Medicine, Columbia University, New York, and Walsh McDermott, M. D., Livingston Farrand Professor of Public Health and Preventive Medicine, Cornell University, New York, and Harold G. Wolff, M. D., Professor of Medicine (Neurology), Cornell University, New York. Ninth edition. 1786 pages. Publication data June 3, 1955.

(*Continued on page* 68)

1950 Cortone® | 1952 Hydrocortone®
1954 'Alflorone' | 1955 'Hydeltra'

DELTRA® tablets
(Prednisone, Merck)
2.5 mg. - 5 mg. (scored)

the delta$_1$ analogue of cortisone

Indications:
Rheumatoid arthritis
Bronchial asthma
Inflammatory skin conditions

SHARP & DOHME
Philadelphia 1, Pa.
DIVISION OF MERCK & CO., INC.



Trasentine®-Phenobarbital

- Inhibits Parasympathetic Activity
- Relaxes Smooth Muscle Directly
- Exerts Local Anesthetic Effect on G-I Mucosa
- Sedates the Patient

Without Atropine Side Effects

Each tablet contains 50 mg. Trasentine hydrochloride and 20 mg. phenobarbital.
Also available: Trasentine hydrochloride Tablets, 75 mg.

Trasentine® hydrochloride
(adiphenine hydrochloride CIBA)

2/20618

C I B A *Summit, N. J.*

MEDICAL HORIZONS TV Monday P.M. *Sponsored by* CIBA ABC-TV

WE CORDIALLY INVITE YOUR INQUIRY for application for membership which affords protection against loss of income from accident and sickness (accidental death, too) as well as benefits for hospital expenses for you and all your dependents.



SINCE 1902

ALL PREMIUMS COME FROM

PHYSICIANS SURGEONS DENTISTS

ALL BENEFITS GO TO

$4,500,000 ASSETS
$22,500,000 PAID FOR BENEFITS

PHYSICIANS CASUALTY AND HEALTH ASSOCIATIONS
OMAHA 2, NEBRASKA

BOOKS RECEIVED (Continued)

$15.00. W. B. Saunders Company, Philadelphia and London.

PATHOLOGY FOR THE SURGEON. By William Boyd, M. D., Edin., Dipl. Psychiat. Edin., F. R. C. S., Canada, F. R. C. P. Lond., M. R. C. P. Edin., F. R. S. Canada, LL. D. Sask, D. Sc. Man., M. D. Oslo. Lecturer on the Humanities in Medicine, The University of Toronto, Visiting Professor of Pathology, The University of Alabama. Seventh edition. 737 pages. 547 illustrations, including 10 in color. Publication date — May 31, 1955. $12.50. W. B. Saunders Company, Philadelphia and London.

THE PRACTICE OF DYNAMIC PSYCHIATRY. By Jules H. Masserman, M. D., Professor of Neurology and Psychiatry, Northwestern University, Chicago, Illinois. 790 pages. Publication date — May 23, 1955. $12.00. W. B. Saunders Company, Philadelphia and London.

DIFFERENTIAL DIAGNOSIS — The Interpretation of Clinical Evidence. By A. McGehee Harvey, M. D., Professor of Medicine and Head of the Department of Internal Medicine, The Johns Hopkins University School of Medicine; Physician-in-Chief, The Johns Hopkins Hospital, and James Bordley Ill., M. D., Director, Mary Imogene Bassett Hospital, Cooperstown, N. Y., Clinical Professor of Medicine, Columbia University, New York; Clinical Professor of Medicine, Albany Medical College. 665 pages. Publication data — June 3, 1955. $11.00. W. B. Saunders Company, Philadelphia and London.

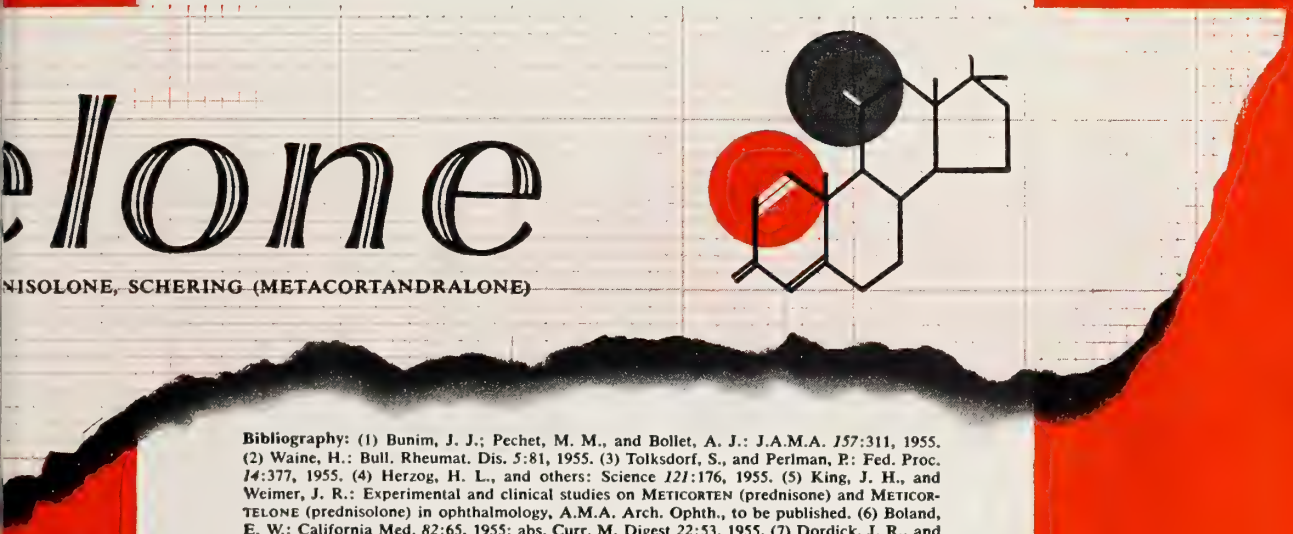
SURGICAL FORUM. Proceedings of the Forum Sessions, 40th Clinical Congress of the American College of Surgeons, Atlantic City, N. J., November 1954. Committee on Forum on Fundamental Surgical Problems, Harris B. Shumacker, Jr., M. D., F. A. C. S., Indianapolis, Chairman, J. Garrott Allen, M. D., F. A. C. S., Chicago, Bradford annon, M. D., F. A. C. S., Boston, Warren H. Cole, M. D., F. A. C. S., Chicago, Robert E. Gross, M. D., F. A. C. S., Boston, J. Albert Key, M. D., F. A. C. S., St. Louis, C. Hunter Sheldon, M. D., F. A. C. S., Pasadena, Howard C. Taylor Jr., M. D., F. A. C. S., New York, and Samuel A. Vest, M. D., F. A. C. S., Charlottesville. 851 pages. Illustrated. Publication date — May 26, 1955. $10.00. W. B. Saunders Company, Philadelphia and London.

COLLECTED PAPERS OF THE MAYO CLINIC AND THE MAYO FOUNDATION. Edited by Richard H. Hewitt, M. A., M. D., A. B. Nevling, M. D., John R. Miner, B. A., Sc. D., James R. Eckman, A. B., M. A., Ph. D., M. Katharine Smith, B. A., Carl M. Gambill, A. B., M. D., M. P. H., Florence Schmidt, B. S. E., George G Stilwell, A. B., M. D. Edition: Volume XLVI — 1954, 843 pages. Publication date — June 1, 1955. 189 figures. $12.50. W. B. Saunders Company, Philadelphia and London.

METICORTELONE possesses antirheumatic and anti-inflammatory effectiveness and hormonal properties similar to those of METICORTEN,[1-5] the first of the new Schering corticosteroids. Both are three to five times as potent, milligram for milligram, as oral cortisone or hydrocortisone. METICORTELONE and METICORTEN therapy is seldom associated with significant water or electrolyte disturbances.

METICORTELONE is an analogue of hydrocortisone, as METICORTEN is of cortisone. The availability of these new steroids, both discovered and introduced by Schering, provides the physician with two therapeutic agents of approximately equal effectiveness.

METICORTELONE is now available as 5 mg. buff-colored tablets, scored, bottles of 30 and 100. In the treatment of rheumatoid arthritis, dosage begins with an average of 20 to 30 mg. (4 to 6 tablets) a day. This is gradually reduced by 2.5 to 5 mg. until daily maintenance dosage, which may be between 5 to 20 mg., is reached. The total 24-hour dose should be divided into four parts and administered *after meals and at bedtime*. Patients may be transferred directly from hydrocortisone or cortisone to METICORTELONE without difficulty.



Bibliography: (1) Bunim, J. J.; Pechet, M. M., and Bollet, A. J.: J.A.M.A. *157*:311, 1955. (2) Waine, H.: Bull. Rheumat. Dis. *5*:81, 1955. (3) Tolksdorf, S., and Perlman, P.: Fed. Proc. *14*:377, 1955. (4) Herzog, H. L., and others: Science *121*:176, 1955. (5) King, J. H., and Weimer, J. R.: Experimental and clinical studies on METICORTEN (prednisone) and METICORTELONE (prednisolone) in ophthalmology, A.M.A. Arch. Ophth., to be published. (6) Boland, E. W.: California Med. *82*:65, 1955; abs. Curr. M. Digest *22*:53, 1955. (7) Dordick, J. R., and Gluck, E. J.: J.A.M.A. *158*:166, 1955. (8) Margolis, H. M., and others: J.A.M.A. *158*:454, 1955. (9) Barach, A. L.; Bickerman, H. A., and Beck, G. J.: Dis. Chest *27*:515, 1955. (10) Arbesman, C. E., and Ehrenreich, R. J.: J. Allergy *26*:189, 1955. (11) Skaggs, J. T.; Bernstein, J., and Cooke, R. A.: J. Allergy *26*:201, 1955. (12) Schwartz, E.: J. Allergy, *26*:206, 1955. (13) Robinson, H. M., Jr.: J.A.M.A. *158*:473, 1955. (14) Dordick, J. R., and Gluck, E.: Preliminary Clinical trials with prednisone (METICORTEN) in systemic lupus erythematosus, A.M.A. Arch. Dermat. & Syph., in press. (15) Nelson, C. T.: J. Invest. Dermat. *24*:377, 1955.

first of the new Schering corticosteroids

METICORTEN

PREDNISONE, SCHERING (METACORTANDRACIN)

- replacing the older corticosteroids in
  rheumatoid arthritis[1,2,6-8]
  intractable asthma[9-12]
  eye disorders[5]
  certain skin disorders such as disseminated lupus erythematosus,[13,14] acute pemphigus,[13,15] atopic dermatitis[15] and other allergic dermatoses
- more active than hydrocortisone or cortisone, milligram for milligram
- relatively free of significant water or electrolyte disturbances [5]

METICORTEN is available as 5 mg. scored, white tablets in bottles of 30 and 100.
METICORTELONE,* brand of prednisolone (metacortandralone).
METICORTEN,* brand of prednisone (metacortandracin). ML-J-55 *T.M.

Renal tuberculosis

by John K. Lattimer, M.D., Transactions, National Tuberculosis Association, May, 1954.

Destructive tuberculosis of the kidneys occurs in about four per cent of patients with pulmonary tuberculosis. As yet, there has been no decline in the incidence of this blood-borne complication as a result of the advent of streptomycin and other drugs.

Undetected renal tuberculosis can be very serious as it tends to be bilateral. The early diagnosis of renal involvement is difficult since it is usually asymptomatic for months or years after its onset. Urinary burning and frequency usually appear later when successful treatment is difficult. All patients with pulmonary tuberculosis should have periodic urine examinations for pyuria for five to ten years after their pulmonary infection. In early involvement of the kidneys, the number of pus cells may be as small as one to three per high power field in specimens of specific gravity 1.015.

The rate of progression of a destructive kidney lesion is highly unpredictable. Some lesions can destroy the kidneys completely within four years, while others may take ten or more years to accomplish this. Rarely the lesions may heal spontaneously. Every renal lesion must be regarded as a dangerous complication. Since both kidneys are usually infected by tubercle bacilli in any hemic dissemination, both may become the site of caseocavernous tuberculosis. Usually, however, one kidney breaks down first. In approximately 50 per cent of patients, the other kidney will break down if untreated.

Renal tuberculosis is always secondary to some other focus in the body. In the United States this focus is usually in the lungs. When a hemic dissemination occurs the glomeruli are infected first, then the region of the narrow loop of Henle. This medullary lesion grows larger to become necrotic and slough out, leaving a small papillary abscess cavity which can empty on the tip of the papilla or in the fornix on either side of the papilla. This is the first lesion of renal tuberculosis which is detectable by X-ray. As the cavity grows it may destroy the entire contents of the renal pyramid served by that papilla. The cavity may then extend out to the very capsule of the

(*Continued on page 74*)

1950 Cortone® | 1952 Hydrocortone®
1954 'Alflorone' | 1955 Deltra®

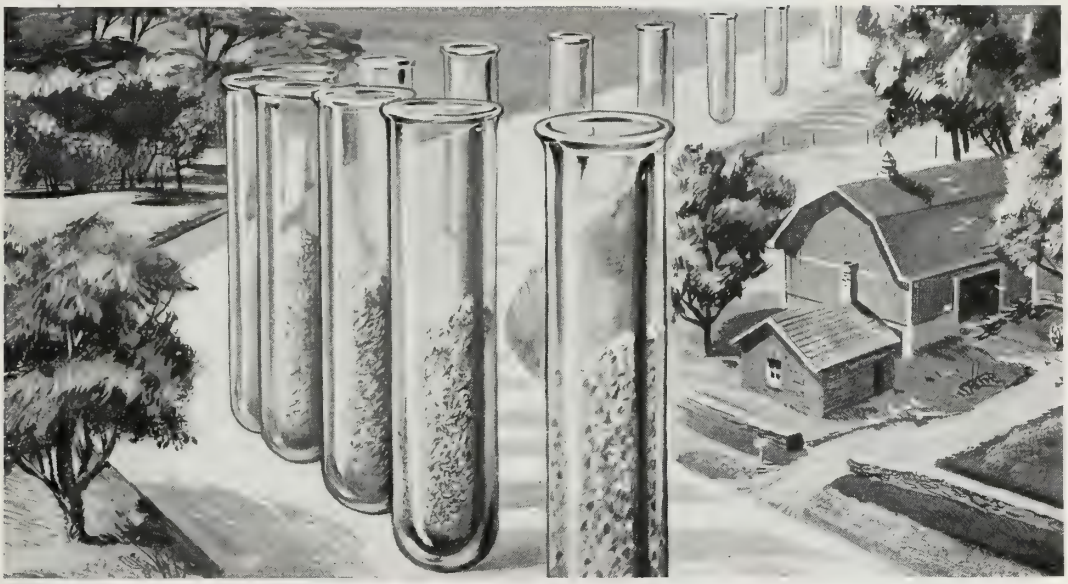
'Hydeltra' tablets
(PREDNISOLONE, MERCK)
2.5 mg.—5 mg. (scored)

the delta, analogue of hydrocortisone

Indications: *Rheumatoid arthritis*
Bronchial asthma
Inflammatory skin conditions

SHARP & DOHME
Philadelphia 1, Pa.
DIVISION OF MERCK & CO., INC.

SECOND REPORT



LECITHIN RESEARCH—AT THE BEND OF THE ROAD

The Therapeutic Usefulness of Lecithin – a natural phospholipid

Because lecithin, a natural, edible food constituent, is an excellent emulsifying agent its application in diseases characterized by disturbed fat absorption and metabolism is logical. Research has proved its value in facilitating intestinal absorption of fats and fat-soluble substances such as Vitamin A.[1-5] For this reason it suggests itself as worthy of trial in treating underweight and steatorrheal diseases (sprue, celiac disease, etc.).

Encouraging results were also achieved in the management of psoriasis, together with dietary and topical measures,[6] and in fatty livers.[7] In the treatment of diabetes, lecithin together with vitamin E has reduced insulin requirements in certain patients.[8] Research on its potentially useful role in the management of the more complicated forms of deranged lipid and cholesterol metabolism – as encountered in essential hyperlipemia, idiopathic familial hypercholesteremia, xanthomatosis, diabetes, etc. – is now being actively conducted.

An excellent source of lecithin is Glidden's "RG" Oil-free Soya Lecithin, a highly purified extract containing a minimum of 95% phospholipids. It is packed in a specially designed 8 oz container to maintain its purity and freshness and is available at your drugstore.

Dosage: Investigators of lecithin have used quantities from 7.5 to 30 grams daily in divided doses. (3 teaspoonfuls equal 7.5 grams.)

Administration: "RG" Lecithin is presented in palatable granules which may be taken plain, in milk, in orange juice or other citrus juices, or sprinkled on cereal.

Literature available on request.

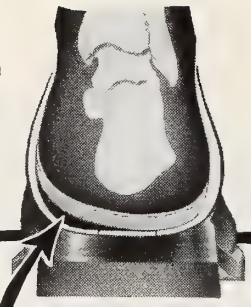
Bibliography: 1. Adlersberg, D., and Sobotka, H.: J. Nutrition *25*:255 (March) 1943. • 2. Adlersberg, D., and others: Gastroenterology *10*:822 (May) 1948. • 3. Adlersberg, D.: New York J. Med. *44*:606 (March 15) 1944. • 4. Adlersberg, D., and others: Am. J. Digest. Dis. *16*:333 (Sept.) 1949. • 5. Augur, V.; Rollman, H. S., and Deuel, H. J., Jr.: J. Nutrition *33*:177 (Feb.) 1947. • 6. Gross, P., and Kesten, M. B.: New York J. Med. *50*:2683 (Nov. 15) 1950. • 7. Schettler, G.: Klin. Wchnschr. *30*:627 (July) 1952. • 8. Dietrich, H. W.: South. M. J. *43*:743 (Aug.) 1950.

GLIDDEN RG® LECITHIN

THE GLIDDEN COMPANY • CHEMURGY DIVISION
1825 North Laramie Avenue, Chicago 39, Illinois

QUALITY Glidden PRODUCTS

Foot-so-Port Shoe Construction and its Relation to Weight Distribution



- Insole extension and wedge at inner corner of heel where support is most needed.
- Special Supreme rubber heels are longer than most anatomic heels and maintain the appearance of normal shoes.
- The patented arch support construction is guaranteed not to break down.
- Innersoles are guaranteed not to crack, curl, or collapse. Insulated by a special layer of Texon which also cushions firmly and uniformly.
- Foot-so-Port lasts were designed and the shoe construction engineered with orthopedic advice.
- **NOW AVAILABLE! Men's conductive shoes. N.B.F.U. specifications. For surgeons and operating room personnel.**
- By a special process, using plastic positive casts of feet, we make more custom shoes for polio, club feet and all types of abnormal feet than any other manufacturer.

Write for details or contact your local **FOOT-SO-PORT** *Shoe Agency. Refer to your Classified Directory*

Foot-so-Port Shoe Company, Oconomowoc, Wis.

RENAL TUBERCULOSIS (Continued)

kidney, which tends to sink in upon the scarred and destroyed calyx. If the abscess does not slough out, it may be seen as a bulging yellow mass of caseous material under the capsule. As the tubercle bacilli and infected caseous material drain into the lumen of the kidney pelvis, other calyces are infected directly. The simultaneous infection of several pyramids often occurs.

Stricture formation as a result of infected material escaping into the kidney, pelvis, ureter, and bladder may choke off the neck of a single calyx, the neck of a major calyx serving half the kidney, or may cause a stricture of the ureter which will kill the entire kidney with great rapidity. Disastrous bladder contractures may eventually follow. The time interval between the primary pulmonary infection and the detection of kidney tuberculosis in one large series averaged eight years. The reason for this long delay is the fact that, even though destruction may be occurring and bacilli going down the ureter, no urinary symptoms are caused for months or years.

Bladder symptoms will eventually occur, how-

(Continued on page 78)

Lederle

FOLBESYN*

Vitamins *Lederle*

A well-balanced, high-potency vitamin formula containing B-Complex and C

FOLBESYN provides B-Complex factors (including folic acid and B_{12}) and ascorbic acid in a well balanced formula. It does not contain excessive amounts of any one factor.

FOLBESYN Parenteral may be administered intramuscularly, or it may be added to various hospital intravenous solutions. It is useful for preoperative and postoperative treatment and during convalescence.

Dosage: 2 cc. daily. Each 2 cc. provides:

Thiamine HCl (B_1)	10 mg.
Sodium Pantothenate	10 mg.
Niacinamide	50 mg.
Ribloflavin (B_2)	10 mg.
Pyridoxine HCl (B_6)	5 mg.
Ascorbic Acid (C)	300 mg.
Vitamin B_{12}	15 micrograms
Folic Acid	3 mg.

FOLBEYSN is also available in tablet form, ideal for supplementing the parenteral dose.

LEDERLE LABORATORIES DIVISION *AMERICAN Cyanamid COMPANY* Pearl River, New York

*REG. U.S. PAT. OFF.

During its seven years of use, AUREOMYCIN has been the subject of more than 8,000 medical papers published in various journals. Reports have been written concerning its value in every field of medicine. Few therapeutic agents have been so well documented.

When a drug has demonstrated its worth, it is usually said to be "established," "accepted," or "proved." If any antibiotic is any of these, AUREOMYCIN is it.

AUREOMYCIN stands on its record!

MYCIN*

Chlortetracycline *Lederle*

Now Available:

AUREOMYCIN SF Capsules, 250 mg.

For Patients with Prolonged Illness AUREOMYCIN SF combines effective antibiotic action with Stress Formula vitamin supplementation to shorten convalescence and hasten recovery. One capsule, q.i.d., supplies one gram of AUREOMYCIN and B complex, C and K vitamins in the Stress Formula suggested by the National Research Council. AUREOMYCIN SF Capsules are dry-filled and sealed, contain no oils or paste.

Lederle LEDERLE LABORATORIES DIVISION AMERICAN Cyanamid COMPANY PEARL RIVER, NEW YORK

*TRADE-MARK

THUMBSUCKING

since infancy caused this malocclusion.



THUM TRADE MARK

THUM broke the habit and teeth returned to normal position.

ACCEPTED FOR ADVERTISING IN PUBLICATIONS OF THE AMERICAN MEDICAL ASSOCIATION

Get Thum at your druggist or surgical dealer.
Prescribed by physicians for over 20 years.

BELLEVUE PLACE

For
NERVOUS and MENTAL
DISEASES

★

Edward Ross, M.D., Medical Director
BATAVIA PHONE
ILLINOIS BATAVIA 1520

RENAL TUBERCULOSIS (Continued)

ever, after a long enough period of time. Hematuria will also eventually occur in most patients if the infection is permitted to persist. Occasionally, hematuria is the presenting symptom. Dull pain over the kidney is frequent, but fever or elevation of the erythrocyte sedimentation rate is rare with renal tuberculosis. Pyuria, together with no pyogenic bacteria on routine culture, should lead to a suspicion of tuberculosis.

The advent of chemotherapy has been a great blessing for patients with kidney tuberculosis. In 1946, even streptomycin alone, produced a dramatic improvement of symptoms in patients whose bladders were not already contracted. The decline in the number of deaths from uremia has been impressive. Combined therapy with PAS and streptomycin, given concurrently for a period of one year, has given considerably better preliminary results than did streptomycin alone. It did not appear to matter whether the streptomycin was given daily or twice weekly.

Isoniazid alone, like streptomycin, does not convert large caseous renal lesions readily and

(*Continued on page* 80)



FOR APPETITE SUPPRESSION

WITHOUT THE "BLACK MOOD" FEELING OF DEPRIVATION

Rauwidrine—containing 1 mg. Rauwiloid® (alseroxylon fraction) and 5 mg. amphetamine in a single tablet—curtails psychogenic overeating without a feeling of deprivation. Especially welcomed by the depressed and obese patient who needs amphetamine, but who suffers jitteriness, cardiac pounding, and insomnia from amphetamine alone. Safe for the hypertensive, too.

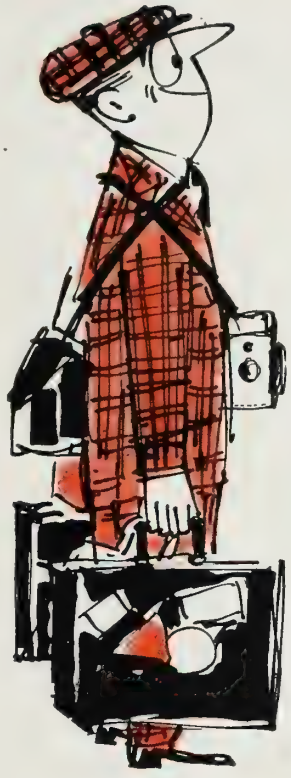
Dosage: For obesity, 1 to 2 tablets 30 to 60 minutes before each meal.

Rauwidrine®

Riker LABORATORIES, INC., Los Angeles



FOR MOOD ELEVATION Rauwidrine provides the needed "lift." Safe for the hypertensive.



A prescription for happy travel . . .



Practically all of your patients, young and old are motion sensitive and suffer to some degree when traveling by rail, bus, automobile, ship or plane. Bonamine easily and effectively prevents motion sickness. A single dose a day often is enough to insure the pleasure and therapeutic benefits of travel. The chewing-gum form has the advantages of patient acceptability, agreeable minty taste and ready availability without need for water for administration.

Bonamine is indicated also for the control of nausea, vomiting and vertigo associated with labyrinthine irritation due to Menière's disease, postoperative status, cerebral arteriosclerosis or radiation therapy.

*Trademark

Bonamine*

Brand of meclizine hydrochloride

***Supplied** as Chewing Tablets, 25 mg. and also as scored, tasteless Tablets, 25 mg.*

Pfizer

PFIZER LABORATORIES, Brooklyn 6, N. Y.
Division, Chas. Pfizer & Co., Inc.

specify

LEDERLE

POLIOMYELITIS IMMUNE GLOBULIN

(human)

Lederle

For the modification of measles and the prevention or attenuation of infectious hepatitis and poliomyelitis.

LEDERLE LABORATORIES DIVISION
AMERICAN Cyanamid COMPANY Pearl River, New York

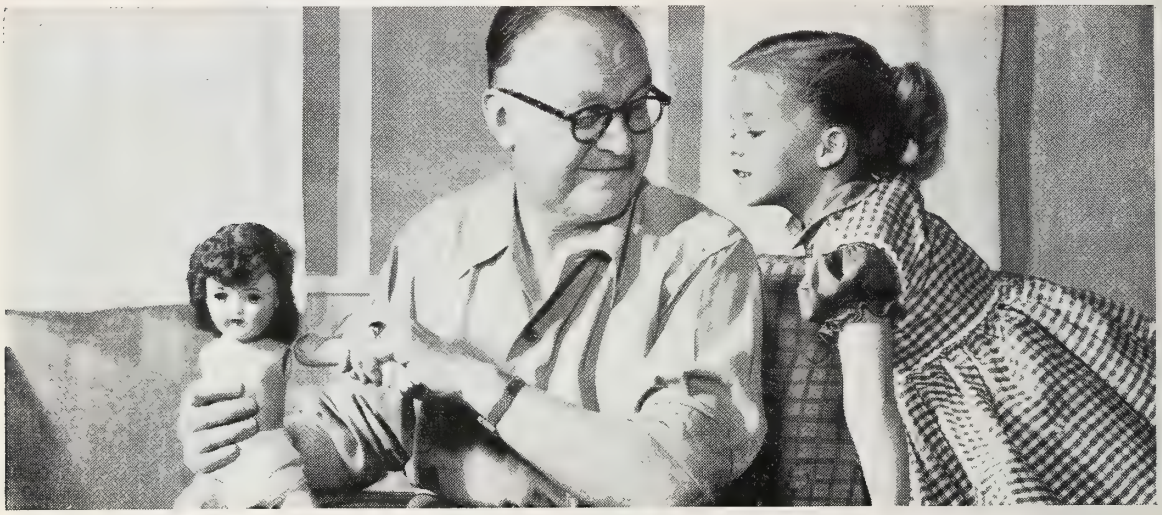
RENAL TUBERCULOSIS (Continued)

often drug resistance appears after several weeks of treatment. Isoniazid has a distinct danger for patients who are uremic. It is a central nervous system stimulant; and among other disadvantages can cause convulsions if the blood level rises too high. Blood levels should be done on all patients who show any elevation of urea nitrogen or whose kidney function is diminished.

Prostatic lesions which have resulted from, and coexist with, renal lesions, or which remain after a tuberculous kidney has been removed, are currently treated with a combined regimen of streptomycin, PAS, and isoniazid for a period of at least one year. Radical prostatovesiculectomy is advised only in the rare cases with intractable pain. A tuberculous epididymis is removed only after three weeks of chemotherapy if the patient is sterile.

Unilateral, destructive tuberculosis of the kidney is probably best treated by nephrectomy followed by one year of combined treatment with streptomycin and PAS. To date, the presence of

(Continued on page 85)



For bigger appetites and better health—at any age

Redisol®
CRYSTALLINE VITAMIN B_{12}

MAJOR ADVANTAGES: Helps patients gain weight. Stimulates hemopoiesis. Elixir and Tablets readily blend with milk, juices and infant formulas.

Supplied as REDISOL Soluble *Tablets:* 25, 50, 100 *mcg.;* cherry-flavored *Elixir:* 5 *mcg.* per 5 cc.; *Injectable:* 30, 100, 1000 *mcg.* per cc.

SHARP & DOHME

Philadelphia 1, Pa.
DIVISION OF
MERCK & CO., INC.

troducing Abbott's new
non-barbiturate hypnotic

Placidyl offers a gentle new therapy for ordinary nervous insomnia.

It relaxes and calms the patient. Tranquil sleep comes within 15 to 30 minutes—should last all night.

Placidyl does not force patients into sleep; rather, it *induces* them to sleep naturally.

Hangover? Not a trace.

Even patients who take Placidyl after waking in the small hours rise clear-headed and refreshed.

Side actions? Virtually none. Not contraindicated in presence of liver or kidney disease. Doses to 1000 mg. show no effect on pulse, blood pressure, respiration, blood, or urine.

Profound hypnotic drugs remain justified for some insomnia patients. But for those whom you wish to give a safer, more gentle source of sleep . . . prescribe this mild new product. Abbott

Not related to the barbiturates, bromides, chloral hydrate, paraldehyde, etc. Available in 500 mg. capsules, bottles of 100. Adult dose for ordinary nervous insomnia 500 mg. at bedtime.

RENAL TUBERCULOSIS (Continued)

any lesion large enough to be visible by X-ray has heralded a poor prognosis for permanent conversion by chemotherapy alone. The newer chemotherapeutic regimens may justify a trial of at least one year of chemotherapy before surgery is advised. The operation should be postponed long enough to make certain that the urine from the contralateral kidney is free of tubercle bacilli and pus cells. In selected cases partial resection of the involved kidney area may be advisable, after four to six months of combined therapy with streptomycin and PAS. The period of treatment should be at least one year.

Bilateral, inoperable renal tuberculosis is now treated with combined chemotherapy for at least one year. If pyuria still persists a second year of treatment may be given. Patients are kept in a semi-ambulatory rest regimen for the first six to twelve months. At the present time regimens employing isoniazid, streptomycin, and PAS together for a period of one year are being tested. Some patients will also be tested on a combination of isoniazid and another tuberculostatic drug for a second year. If one kidney is only slightly worse than the other, the worse kidney should not be removed. The patient will only die sooner.

Prostatic and epididymal tuberculosis are now being treated with one year of combined chemotherapy. Epididymectomy is advised for lesions which are obviously very large, caseous, or necrotic. The operation is followed with one year of combined chemotherapy.

Eight years of observation of bacteriological data, roentgenographic data and symptomatic and survival data have convinced us that modern chemotherapy is certainly effective in modifying the formerly lethal course of renal tuberculosis. A careful search for small numbers of pus cells in the urines of all patients with a history of pulmonary tuberculosis is the most valuable test which can be done, for it may lead to the early detection and successful treatment of this disease.

‹ ›

With our heritage and modern scientific tools, plus a sustained intensive search for the facts and a fundamental belief in our capabilities, we will need only a little luck to bring about the eradication of tuberculosis in a much shorter time than now seems possible. Floyd M. Feldmann, M.D., Bull. Nat. Tuberc. A., April, 1955.

Another Lederle "First"!

MUMPS VACCINE

A practical immunizing antigen for prevention of mumps in children or adults where indicated.
Immunizes for about one year.
Packages: 2 cc. vial (1 immunization),
10 cc. vial (5 immunizations).

LEDERLE LABORATORIES DIVISION
AMERICAN Cyanamid COMPANY
PEARL RIVER, NEW YORK

Lederle

The response to anxiety

Every person has symptoms of emotional origin at varying times in life. There are many simple examples of how tension may result in physical symptoms. One who is called on to make a speech, for example, has a dry mouth, a tight feeling in his stomach, is frequently unable to eat and may have an uncontrollable tremor. You are all familiar with anger in which a person has a flushed face, his fists are frequently clenched, and which can result in headache. A near-accident will cause one to feel weak and have cardiac palpitation, but this certainly does not mean organic heart disease. It certainly is not hard to explain to a patient that his symptoms are the body's "normal" response to prolonged anxiety or tension and are not indicative of dread disease or an incurable lesion. It is very important to tell a patient that a certain amount of tension and stress is a normal part of every day life. This, if prolonged, can result in physical symptoms. *Wade H. Boswell, M.D. Iatrogenic Disease. J. Tennessee State M. A. July* 1955.

1950 Cortone® | 1952 Hydrocortone®
1954 'Alflorone' | 1955 Deltra®

'Hydeltra' tablets
(PREDNISOLONE, MERCK) 2.5 mg.—5 mg. (scored)

the delta, analogue of hydrocortisone

Indications: *Rheumatoid arthritis*
Bronchial asthma
Inflammatory skin conditions

SHARP & DOHME
Philadelphia 1, Pa.
DIVISION OF MERCK & CO., INC.

1950	1952	1954	1955
Cortone®	Hydrocortone®	'Alflorone'	Deltra®

the delta, analogue of hydrocortisone

'Hydeltra' tablets

(Prednisolone, Merck)

2.5 mg.-5 mg.

(scored)

'Hydeltra'

Indications: RHEUMATOID ARTHRITIS
BRONCHIAL ASTHMA
INFLAMMATORY SKIN CONDITIONS

'Hydeltra' offers increased clinical effectiveness . . . lowers the incidence of untoward hormonal effects.

'Hydeltra' is supplied as 2.5 mg. and 5 mg. scored tablets in bottles of 30 and 100.

SHARP & DOHME

Philadelphia 1, Pa.
DIVISION OF MERCK & CO., INC.

HYDELTRA *is the trade-mark of Merck & Co., Inc. for its brand of prednisolone, supplied through Sharp & Dohme, Division of Merck & Co., Inc.*



MARY POGUE SCHOOL, Inc.

Complete facilities for training retarded and epileptic children educationally and socially. Pupils per teacher strictly limited. Excellent educational, physical and occupational therapy programs.

Recreational facilities include riding, group games, selected movies under competent supervision.

Separate buildings for boys and girls under 24 hour supervision of skilled personnel.

Catalog on request

G. H. Marquardt, M.D. — *Medical Director*

Barclay J. MacGregor — *Registrar*

33 GENEVA ROAD, WHEATON, ILLINOIS

(near Chicago)

Classified Ads

RATES FOR CLASSIFIED ADVERTISEMENTS—For 30 words or less: 1 insertion, $3.00; 3 insertions, $8.00; 6 insertions, $14.00; 12 insertions, $24.00; from 30 to 50 words: 1 insertion, $4.00; 3 insertions, $10.50; 6 insertions, $20.00; 12 insertions, $30.00. Extra words: 1 insertion 10c each; 3 insertions, 25c each; 6 insertions, 40c each; 12 insertions, 50c each. A fee of 25c is charged for those advertisers who have answers sent care of the Journal. Cash in advance must accompany copy.

WANTED: General practitioner wishes to locate in northern Ill. Will consider association or partnership with other physician or small group. Box 227 Ill. Med. Jl. 185 N. Wabash, Chicago 1, Ill.

WANTED: Physician to fill vacancy left by Dr. Prescott, deceased. Physician badly needed, will have all he can do. Fully equipped office available. Contact Mrs. H. V. Prescott, Dallas City, Ill.

FOR SALE: 15 room brick veneer mod. res., $100,000 orig. cost. Auto., gas heat., like new. Wealthy farm comm., central Ill. Avail. fraction of cost or terms. Excel. oppty. for large pract. & use as clinic. Dr. with hosp. facil. needed. Contact V. A. Wiese, Robeson Bldg., Champaign, Ill. for information. 12/55

FOR SALE: Estab. eye, ear, nose & throat pract. Same location 35 yrs. Suburb of Chicago serving 75,000 including indust. center. Retiring because of poor health. Give qualifications. Box 226 c/o Ill. Med. Jl. 185 N. Wabash, Chicago 1.

FOR RENT: One seven room air conditioned physicians suite suitable for one or two doctors. One four room dental suite in well established medical center. 110 bed hospital, open staff. Ample parking. Doctor owner. Contact Mrs. Martha Robinson, 122½ N. Avenue A., Canton, Illinois. 12/55

WANTED: Rural practitioner for Patoka, Illinois. Population 600, large trading area. May practice to replace present physician while in military service. Write C. D. Martin, Patoka, Illinois.

The plain truth is that the enigma of tuberculosis is far from being solved, in spite of the decreasing death rates and the gradual decline in case rates. Manifestations of the disease and the organism associated with it have been studied by a host of distinguished scientists. A tremendous background of information has been collected, but many of the most basic and crucial facts seem to be just beyond our reach. Our present position could be described as optimistic and at the same time frustrating. Opportunities for advances in the control of tuberculosis are more numerous than ever before, but it is obvious that we are not accepting fully the responsibilities thrust upon us by the rapid scientific progress of recent years. Floyd M. Feldmann, M.D., Medical Director, NTA, Bull. Nat Tuberc. A., April, 1955.

THE SPECIAL DISABILITY PLAN AVAILABLE TO MEMBERS OF THE ILLINOIS STATE MEDICAL SOCIETY Offers You — —

INDEMNITY FOR TOTAL LOSS OF TIME payable for up to
LIFETIME if due to an accident
7 YEARS if due to a sickness

HOSPITAL EXPENSE BENEFIT payable up to 90 days of confinement
ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

No reduction in benefits because of other similar insurance. Full benefits to age 70 at same cost.
(All benefits subject to provisions of the policies)

FOR ALL THE FACTS — — — WRITE OR TELEPHONE

PARKER, ALESHIRE & COMPANY

175 W. Jackson Boulevard

Chicago 4, Illinois **WAbash 2-1011**

THE KEELEY INSTITUTE
DWIGHT, ILLINOIS

Treating alcoholism and other problems of addiction.

REGISTERED BY THE AMERICAN MEDICAL ASSOCIATION— MEMBER AMERICAN HOSPITAL ASSOCIATION.

Table of Contents

November, 1955
Vol. 108, No. 5

Editor
Harold M. Camp
Monmouth, Illinois

Associate Editor
Theodore Van Dellen
Chicago, Illinois

Business Manager and Managing Editor
Mr. L. E. Malley
185 N. Wabash Avenue
Chicago 1, Illinois

Business Office
185 N. Wabash Avenue
Chicago 1, Illinois

Editorial Office
Medical Arts Building
Monmouth, Illinois

Send original articles and membership correspondence to Harold M. Camp, Monmouth, Ill.

Send changes in the mailing list to Managing Editor, 185 N. Wabash Ave., Chicago 1, Ill.

Subscription price of this JOURNAL to persons not members of the Illinois State Medical Society is $4.00 per year, in advance, postage prepaid, for the United States, Cuba, Puerto Rico, Philippine Islands, Hawaiian Islands and Mexico. $5.00 per year for all foreign countries included in the postal union. Canada, $4.50. Single current copies 50 cents. By mail, 60 cents.

ORIGINAL ARTICLES

Virus Problems in Medicine, Thomas Francis, Jr. M.D., Ann Arbor, Michigan 257
Putting New Members to Work, Russell B. Roth, M.D., Erie, Pennsylvania 261
Alcohol Inhalation in the Treatment of Acute Pulmonary Edema in the Immediate Postoperative Period, Ruth Weyl, M.D., Chicago . 265
The Thermonuclear Fall-Out Problem in the State of Illinois, Charles L. Maxwell, M.D., Chicago 269
Missed Abortions, Harold E. Smith, M.D., F.I.C.S., F.A.C.S., Maywood 273
Newer Concepts of Diseases of the Gastro-Intestinal Tract, (Seminar) H. Necheles, M.D., Chicago 275
Trichomonas Vaginitis, Diagnosis and Treatment with Milibis, Walter J. Reich, M.D., Mitchel J. Nechtow, M.D., M. William Rubenstein, M.D., A. M. Doswald, M.D., Chicago 278
Pericardial Tamponade Due to Tuberculous Pericarditis, (Cook County Case Record) John C. Kulis, M.D. and William Saphir, M.D., Chicago 280
Chronic Gastro-Intestinal Hemorrhage, Diagnostic Enigma, (Case Report) Charles W. Pfister, M.D. and B. J. Tatarowicz, M.D., F.A.C.S., Chicago 283
Situs Inversus Viscerum (Case Report) Glenn E. Wright, M.D., Woodstock 286

PATHOLOGY CONFERENCES

1. Embolic infarcts of the brain and other viscera with chronic rheumatic endocarditis.
2. Acute thrombo-ulcerative endocarditis of the mitral valve, Edwin F. Hirsch, M.D., Chicago 287

EDITORIALS

Urogenital cancer in children 293
Dr. Telford "G.P." of Year 293
Prevention of rheumatic fever 294
Do you plan to build—remodel—or rent? 294
The Illinois plan for the distribution of poliomyelitis vaccine 295
Postgraduate conferences in Illinois 297
The woman's auxiliary 298
Booklet on indigent care plans 299
Early medical public relations in Illinois 299
Clinical meeting of the A.M.A. 300
Book Reviews 74A

MEDICAL ECONOMICS

Public Relations, Caesar Portes, M.D., Chicago 301

THE P. R. PAGE

..... 303

CORRESPONDENCE

Blue cross increases benefits and membership dues 305
A.M.A. official tour to Nassau 305
American Goiter Association 306
Chest Physicians essay contest 306
Fellowships in industrial medicine 306
Clinics for crippled children listed for December 307
Physical Therapy Examination 307

NEWS OF THE STATE

..... 308

Entered as Second-Class Matter November 12, 1952 at the Post Office, Mendota, Illinois, under the Act of March 8, 1879. Acceptance for mailing at special rate postage provided for in section 1102, Act of October 8, 1917, authorized July 15, 1918. Printed monthly by The Wayside Press, Mendota, Illinois. Office of Publication, 1501 W. Washington Road, Mendota, Illinois. POSTMASTER — Return undeliverable copies under form 3579 to 1501 W. Washington Road, Mendota, Illinois.



3 TYPES OF PERSISTENT PAIN

with psychic side effects

As the conditions that cause these types of pain persist, the patient becomes more and more preoccupied with his pain. The depression, nervous tension and anxiety that nearly always accompany such pain combine to intensify and prolong it.

'Daprisal' relieves these psychic aspects of pain because it provides the mood-ameliorating effect of Dexamyl* (Dexedrine† and amobarbital). It brings about a feeling of energy and well-being, and restores optimism.

'Daprisal' works to relieve the pain itself because it provides the combined analgesic effect of acetylsalicylic acid and phenacetin, *potentiated* by amobarbital.

DAPRISAL*

for the relief of pain and psychic side effects of pain

Smith, Kline & French Laboratories, Philadelphia 1

FORMULA: Each 'Daprisal' tablet contains 'Dexedrine' Sulfate (dextro-amphetamine sulfate, S.K.F.), 5 mg.; amobarbital, ½ gr. (32 mg.); acetylsalicylic acid, 2½ gr. (0.16 Gm.); phenacetin, 2½ gr. (0.16 Gm.).

*T.M. Reg. U.S. Pat. Off.
†T.M. Reg. U.S. Pat. Off. for dextro-amphetamine sulfate, S.K.F.



from this

to this



safely

with **AM PLUS**®

(dextro-amphetamine plus minerals and vitamins, Roerig)

each AM-PLUS capsule contains:

Dextro Amphetamine Sulfate U.S.P.	5 mg.
Vitamin A (Palmitate)	5,000 U.S.P. Units
Vitamin D (Irradiated Ergosterol)	400 U.S.P. Units
Thiamine HCl U.S.P.	2 mg.
Riboflavin U.S.P.	2 mg.
Pyridoxine HCl U.S.P.	0.5 mg.
Niacinamide U.S.P.	20 mg.
Ascorbic Acid U.S.P.	37.5 mg.
Calcium Pantothenate	3 mg.
Calcium (from Dicalcium Phosphate)	242 mg.
Cobalt (from Cobaltous Sulfate)	0.1 mg.
Copper (from Cupric Sulfate)	1 mg.
Iodine (from Potassium Iodide)	0.15 mg.
Iron (from Ferrous Sulfate)	3.33 mg.
Manganese (from Manganous Sulfate)	0.33 mg.
Molybdenum (from Sodium Molybdate)	0.2 mg.
Magnesium (from Magnesium Sulfate)	2 mg.
Phosphorus (from Dicalcium Phosphate)	187 mg.
Potassium (from Potassium Sulfate)	1.7 mg.
Zinc (from Zinc Sulfate)	0.4 mg.

dosage: Two or three capsules daily, one-half hour before meals.

In bottles of 100 soft, soluble capsules.

1. MacBryde, C. M.: in Current Therapy, W. B. Saunders Co., Philadelphia, 1953, p. 350.

Adequate minerals and vitamins must be supplied in any long-continued weight reducing program.[1]

AM-PLUS: Supplies 11 important minerals and 8 essential vitamins **and** decreases appetite and elevates mood—safely—with dextro-amphetamine.

ROERIG Rx **Chicago 11, Illinois**

Cardiac injury

Some cardiac injuries are fatal instantaneously. If the injury is from a stabbing or shooting, bleeding may cease and one is concerned only with a cardiac tamponade. This should be suspected when the heart sounds become faint, the systolic blood pressure falls, and venous engorgement is evidenced by distended neck veins. The pulse is often paradoxical. An enlarging cardiac shadow on the X-ray is significant. These changes are due to a rather sudden increase in pressure on the heart which interferes with blood flow to the heart and causes an increase in pressure in the vena cavae and entire venous system. If the pericardium is torn so that it communicates with the pleura, the blood will escape into the pleural space and there will be evidence of hemothorax and shock from blood loss, conditions which do not respond to resuscitative measures. Emergency treatment includes oxygen and blood replacement. Recent reports verify the fact that pericardicentesis may be lifesaving and also be definitive therapy. The aspiration should be done in the semi-erect position or prone position through the fourth left interspace or subxiphoid route. A subsequent aspiration may be necessary. If the patient responds only to lapse again into difficulty, continued bleeding should be suspected and open exploration performed. *Allen E. Greer, M.D., Chest Injuries. J. Oklahoma M.A. May 1955.*

The cold war against tuberculosis calls for a clear-cut program for the future. It is regrettable, that in our satisfaction with the fall in death rates, we may have given the impression that tuberculosis is conquered. In fact, some in authority have said that the fight is as good as over and that there will be no tuberculosis problem in ten to twenty years. This breezy optimism is founded on lack of knowledge and misunderstanding of the problems involved. Tuberculosis, while it has lost many of its death-dealing features, is still the greatest single cause of loss of man-hours in young people and still disrupts thousands of homes. George J. Wherrett, M.D., Nat. Tuberc. A. Tr., May, 1954.

1950 Cortone® | 1952 Hydrocortone®

1954 'Alflorone' | 1955 'Hydeltra'

DELTRA® tablets

(Prednisone, Merck)

5 mg. - 2.5 mg. - 1 mg. (scored)

the delta-1 analogue of cortisone

Indications:

Rheumatoid arthritis

Bronchial asthma

Inflammatory skin conditions

SHARP & DOHME

Philadelphia 1, Pa.

Division of Merck & Co., Inc.

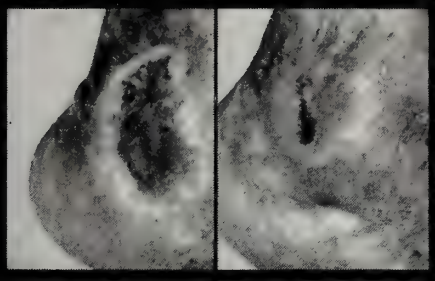
relieves
pain
and itching...
stimulates
healing

even
when
other
therapy
fails...



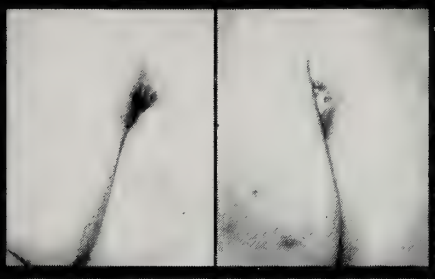
left
Traumatic ulceration with edema in a paralyzed arm

right
Almost complete healing with Panthoderm Cream applied twice daily for three weeks



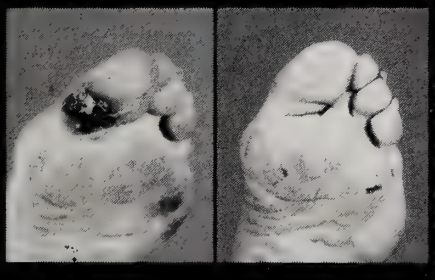
left
Varicose ulcer of ankle, large, deep, profuse foul-smelling discharge

right
Healing of ulcer after treatment with Panthoderm Cream for ten weeks



left
Gangrenous ulcer of the buttocks

right
Healing after twice daily application of Panthoderm Cream for four weeks



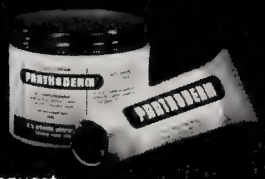
left
Diabetic ulceration of great toe of two months' duration; unresponsive to previous therapy

right
Complete healing after two weeks therapy with Panthoderm Cream

panthoderm cream

2% Pantothenylol (analog of pantothenic acid) in a water-miscible base

non-sensitizing
aesthetically agreeable



available in 1 oz. tubes; 2 oz. and 1 lb. jars

SAMPLES and literature available upon request

u. s. vitamin corporation

Arlington-Funk Laboratories, division, 250 East 43rd Street • New York 17, N.Y.

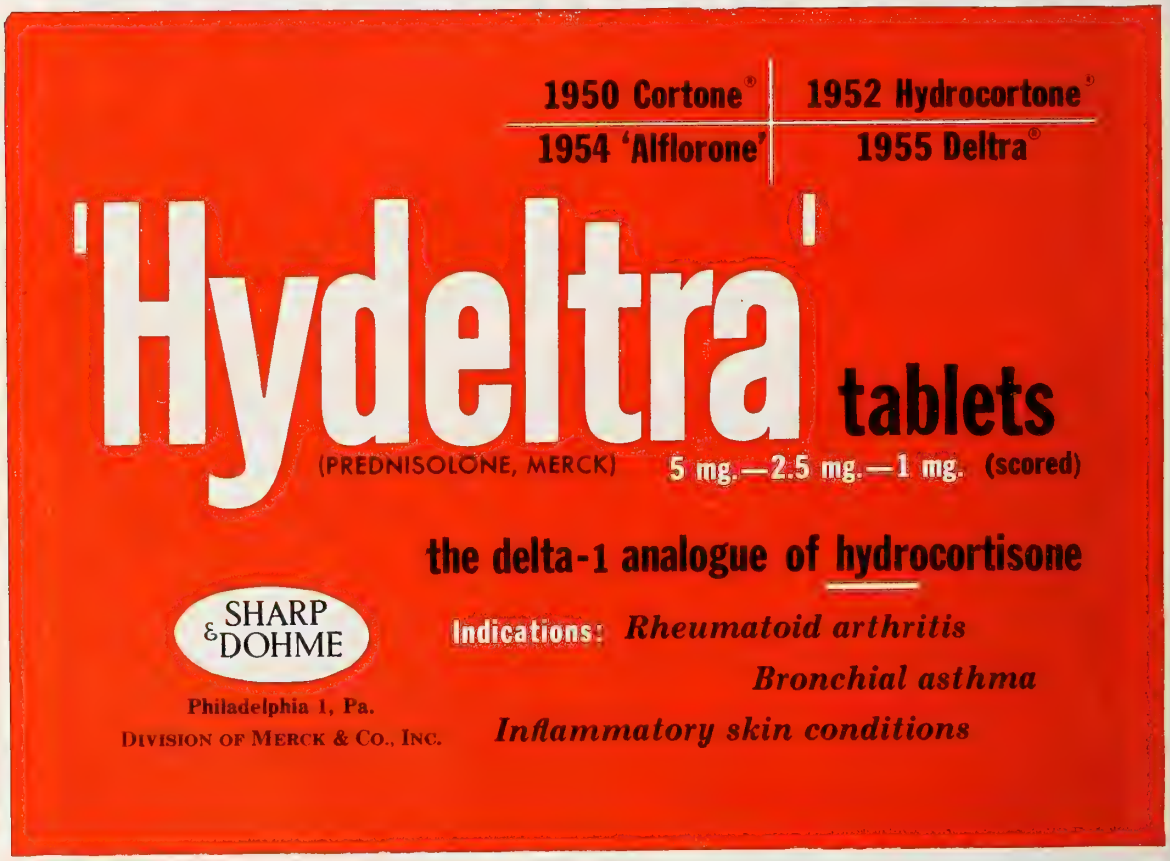
Cobalt irradiation

The advantages of cobalt irradiation over conventional X-ray treatment, according to Smith, rest in the fact that a greater dosage of rays can be directed to tissues and organs in the interior of the body with less danger to surface and other intervening tissue. He also believes cobalt enables patients to tolerate a greater dosage of irradiation to a particular organ and the body in general in a shorter time. There is still, however, a narrow breach between the amount of irradiation from any source which can be tolerated by normal tissue and the dosage necessary to cause lethal tumor damage, said Smith. The radiotherapist's major clinical problem today, in his opinion, is to find chemotherapeutic agents which will widen that breach. Any form of irradiation, he said, is futile against widespread cancer, except for the temporary relief of symptoms, and then conventional X-ray therapy will bring the desired results. Leukemia and Hodgkin's disease are outside the cobalt realm, he stated. *Cobalt Beam Therapy Aids Cancer Patients. Pub. Health Rep. Feb. 1955.*

Ventricular tachycardia

Ventricular tachycardia usually is a complication of an acute coronary thrombosis or an old infarct in the heart muscle. Rarely is it present as a result of gumma of the myocardium or rare forms of myocarditis or drug intoxication. Quinidine sulfate probably is the drug of choice for management. A simple plan of therapy is a 3 grain dose every two hours for eight hours or cessation of the attack. If unsuccessful, a repetition of the program on 6 grain dosage schedule may be employed, with hourly feedings to minimize gastrointestinal irritation. Intravenous use of quinidine also has been successful. Prophylactic use of quinidine in all coronary patients with premature ventricular systoles has been advocated. *Chauncey C. Maher, M.D. Cardiac Irregularities. Rocky Mountain M.J. April 1955.*

A normal roentgenogram of the chest at the age of forty in no way precludes the possibility of finding progressive reinfection tuberculosis at a later date. E. M. Medlar, Am. Rev. Tuberc., March, 1955.



The
ILLINOIS
Medical Journal



Official Journal of The Illinois State Medical Society

NOVEMBER 1955
VOL. 108 NO. 5

Virus Problems in Medicine

Thomas Francis, Jr., M.D., Ann Arbor, Michigan

THE title proposed for the Oration in Medicine offers a wide range of possibilities; it implies, nevertheless, a concentration of attention on certain basic problems. Limitation of discussion to *virus* problems brings promptly to mind the concept of specific etiology, a principle established so effectively in the field of infectious disease that it has become a dominating influence in the investigation of all sorts of disease and disability. It is often objected that attention to the idea of a primary causative agent has ignored other influences, such as the physiologic or sociologic, which may play an important part in deciding whether the person subjected to the primary agent will acquire the infection or the more pronounced manifestations which we call "the disease." Consequently, the term, multiple causation, has evolved. Granted that multiple factors may contribute to the causation of a specific disease or that a disease like pneumonia may be associated with a variety of different agents, it is equally clear that in the absence of the primary infectious agent, that particular disease entity does not occur. Moreover, when specific immunization or treatment limits the action of the infecting organism the subject can be protected despite the presence of associated factors which may be considered contributory. On this basis virus problems in medicine will be discussed from the viewpoint of viruses as primary etiologic agents of disease.

The steadily increasing investigation of many clinical syndromes in the past 25 years has resulted in an expanding list of diseases, some newly recognized, some of ancient and honorable history, which are now established to be of viral etiology. This progress has resulted not only in the clarification of etiologic entities but has established their usual clinical manifestations and provided the means for mapping the epidemiologic patterns of their distribution, their reservoirs and methods of transmission.

REMOTE EFFECTS OF VIRUS INFECTION

In the majority of instances the interval between infection and onset of disease is relatively short so that correlation between the incident of infection and subsequent illness is readily suggested. The illnesses, too, may be of short, self-limiting duration so that the entire experience

From the Department of Epidemiology and Virus Laboratory, School of Public Health, Ann Arbor, Michigan.

Presented as the Oration In Medicine before Annual Meeting of the Illinois State Medical Society, Chicago, Illinois, May 18, 1955.

Certain of these studies were conducted under a grant from the National Foundation for Infantile Paralysis, Inc.

is an acute episode. There is, however, an increasing interest in the role of viruses as causative agents of disease in which, because of the extended period between the time of infection and the appearance of clinical manifestations, the correlation is not readily made. This is well illustrated by the story of serum hepatitis. Although its relation to infection transmitted by inoculations had been earlier suggested, it was not until the extensive occurrence of jaundice after vaccination for yellow fever that the association became clearly established. The recorded dates of inoculation with specific lots of the vaccine provided a firm basis for establishing an incubation period of 90 to 120 days as the usual interval and interestingly, there was no evidence of transfer by association with known infected persons. It has been subsequently shown that the virus may be present in the blood for two months or more before onset of clinical signs and for extended periods without obvious disease.

A somewhat different but temporally remote association is that reported between the occurrence of German measles during the first trimester of pregnancy and the subsequent recognition of congenital cardiac abnormalities in the child. Whatever the precise mechanism may be, it is apparent that certain virus infections of the mother at this time increase the likelihood of developmental disturbances.

Still another example is that suggested by the studies of Shope with swine influenza virus. They indicate that virus in the lungs of infected swine take up residence in the ova of parasitic lung worms which are coughed up by the hog. They are ingested by earth worms, undergo different stages of development in them and the earth worm is then eaten by a hog. The lung worm larve migrate to its lungs. Influenza virus, although not indentifiable in the lung worm ova or larvae is apparently present, because provoking stimuli at the right season will disturb the relationship between virus and the worm, the virus erupts and infects the hog. This masked phase may extend for a period of a year or more before infection of the swine host takes place.

The extended time relationships between virus infection and malignant tumors have been extensively documented. The development in man of cancer in warts of probable viral origin is an old clinical observation. Rouse and his associates presented classic observations of the occurrence of carcinomata in rabbits initially bearing benign tumors caused by the Shope papilloma virus. The milk factor of Bittner—probably a virus—is transmitted through the milk of the mother to the nursing offspring with the result that mammary cancer develops in adult life although the virus was acquired in the first days of life. The studies of Duran-Reynals with the Rous-sarcoma demonstrated that inoculation of virus in newly hatched fowl resulted in malignancy in the adult chicken. The fact that localization of inoculated virus at sites of induced cutaneous ulceration enhances the occurrence of malignancies is further indication of virus influence. In fact, it has been strongly urged that carcinogenic compounds only activate a dormant virus which may be present or that hormonal changes have their primary influence on carcinogenic viruses.

These extended temporal relationships between virus infection and the appearance of associated disease phenomena readily project the possibility that viruses are involved in the etiology of other diseases which at present appear to be unrelated to infection. The capacity of Coxsackie virus to damage the pancreas in mice, suggests the possibility that it may occur in man. There are those who support the thesis that hyperthyroidism is a virus infection. Other diseases considered degenerative may also be suspected. Although this is in the range of speculation, it seems likely that viruses, either chronically persistent, dormant or slow of action, will be found associated with diseases hitherto unsuspected of viral etiology.

THE PROBLEM OF PREVENTION AND TREATMENT

The preceding phase of the discussion has been concerned with the establishment of viral etiology of disease and while it suggests the another problem of fundamental importance. enlarged scope of virus infection it also poses What can be done about it? One of the outstanding demonstrations of the present era has been the failure of chemotherapeutic agents to influence the course of viral disease, once established, with the exception of those such as psittacosis and lymphogranuloma whose agents more closely appear to resemble rickettsiae than

the rest of the viruses. No more have immunologic procedures been influential in treatment except under certain limited experimental conditions. This refractoriness is substantial evidence of differences in the mechanisms of virus growth and infection and those exhibited by a large proportion of bacterial agents. It is commonly accepted that viruses require an intracellular location for their propagation and that this is rapidly acquired after a virus comes in contact with the specific susceptible cell whose injury creates the pathologic clinical picture. The need for an intracellular localization appears to be related to the fact that the constituents and energy required by the virus for its development and multiplication cannot be prepared by the virus itself but are provided by the metabolic processes of the living cell. Hence, growth and vitality of the cell appear to be intimately tied to those of the virus and once integrated with the vital functions of the cell the virus is apparently protected against influences which might prevent its development. The efforts to gain knowledge of pathogenesis of viral disease, therefore, have moved closer and closer to studies at the cellular level and it has been steadily observed that a brief interval after virus has penetrated cells, inhibitory effects are difficult to obtain.

a) *The Immunologic Approach*: The accumulated data from a variety of studies, therefore, direct attention to prevention as the most promising basis for control of virus diseases. This is, of course, the fundamental outlook of clinical immunology. But if, to prevent virus diseases a specific vaccine must be prepared against each one, the task seems enormous and the practicability of innumerable inoculations or administrations creates a definite problem. Moreover, there is considerable difference of opinion concerning the processes involved in establishing a firm immunity. One school holds that the continued immunity observed after many virus diseases is maintained by a persistence of active, modified or masked virus in the tissues of the recovered person where it continuously provides an antigenic stimulus to the persistence of antibody. This is despite the contradictory fact discussed earlier, that dormant or latent virus may be a basis for delayed disease manifestations, and also, that when virus can be actually demonstrated to persist after infection, relapses or late recurrences are more likely than permanent immunity. This is illustrated by herpes simplex.

However, non-living antigens may also persist in cells for extended periods and there is still strong support for the thesis that inactivated virus can induce an effective resistance to virus disease. The studies in influenza have built evidence, through a decade, that an inactivated virus vaccine containing the proper antigenic components can be highly effective against the epidemic disease. But influenza also presents the problem of multiple types of virus and multiple variations within the types.

The argument between the outlook for inactivated virus vaccines in prevention and that for active, modified virus has proceeded briskly during the current interest in vaccination against poliomyelitis. The decision as to which may be more effective or durable is not going to be reached by authority but by actual investigation —by looking in Mrs. Aristotle's mouth. There is little doubt from the 1954 field trial that inactive virus had a distinct protective influence. Immunologically my leaning is toward inactive vaccines because the risks and the difficulties should be sharply reduced and reinoculation should enhance resistance if it is obtained. But I would go further: if the complicated problem of so many different virus diseases and of many antigenic variants is to be met by inactive vaccination, the possibility of extracting the essential components from the viruses needs to be carefully explored in the hope that they can be combined for multiple prophylaxis. The possibility of administering multiple, active, modified viruses can also be considered.

b) *The Chemical Approach*: Still another probability exists despite the failures of chemotherapy in virus diseases to date. That is prophylaxis by use of chemicals or antibiotics. The close relation of cell metabolism and virus growth has suggested that materials which interfere with certain of the basic biochemical processes leading to protein formation by the cell may interfere with virus synthesis by lack of the same essential components. Studies in our laboratories by Ackermann and his associates demonstrated that competitive analogues of methionine, an essential amino acid, could completely inhibit the development of influenza virus in tissue cul-

tures.[1] Brown and Ackermann[2] demonstrated that ethionine would also prevent the growth of poliomyelitis in cultures of embryonic brain tissue. That the virus was not specifically killed, nor the cells seriously damaged was shown by the fact that the effect could be reversed by addition of l-methionine. Proceeding along these lines of biochemical interference it has been possible to distinguish several stages of viral development according to their susceptibility to inhibition by chemicals with different modes and times of reaction.[3]

Stage		*Inhibitor*
1. virus adsorption		alpha-amino-sulfonic acid (Amps)
2. Penetration		
3. Organization	Stage 1—	Methoxinine
	Stage 2—	Fluorophenylalanine (4)
4. Maturation		None found
5. Liberation		Amps - reversed by RDE*

* Receptor destroying enzyme of cholera vibrio

The suggestion here is that effects are most likely obtained in the early phases of virus adsorption and organization whereas at later stages production proceeds at an undiminished rate even though the release may be retarded by inhibitors.

Ackermann[5] showed that sodium fluoroacetate, which interferes with the citric acid cycle, would, when given shortly after infection, markedly delay the development of influenza virus in the lungs of mice. Ainslie[6] showed that the same compound delayed, for at least a generation time, the development of poliomyelitis virus in the brains of mice. Subsequently, we showed that when fluoroacetate was given to monkeys intravenously at the same time as poliomyelitis virus was given subcutaneously, a distinct protective effect occurred.[7] In each of six experiments all the controls developed paralytic poliomyelitis, while one or two of the treated animals escaped —a total of nine of forty-two. This may appear to be a limited effect but it really is a highly significant and important demonstration of chemoprophylaxis of a viral infection—poliomyelitis.

Later, a crude filtrate of a mold culture which had been shown by Powell and Culbertson[8] to have an effect upon certain neurotropic viruses in mice, was studied for its effect upon poliomyelitis in monkeys. Cochran, Brown and I[9] observed that when given intraperitoneally in three doses in the 24 hours prior, and again four hours after subcutaneous inoculation of a limited amount of virus, clearcut protective effect was obtained. Only four of 24 monkeys so treated developed paralysis with delayed incubation periods while 14 of 25 controls came down. This again is a noteworthy event. The fact is clearly established that effective chemoprophylaxis can be anticipated. And it seems probable that the principles in action against one virus may well carry over into a generalized principle applicable to a number of virus infections. One can visualize materials of a nature which may become part of a daily diet or intake having a broad protective effect in the general population. The multiplicity and immunologic complexity of the virus agents of disease recommend this outlook. The fact that diseases caused by the rickettsiae and the psittacosis-lymphogranuloma agents are susceptible to treatment with sulfonamides and antibiotics strongly supports it. Experimental data such as I have mentioned against influenza and poliomyelitis viruses readily project the probability that the practical application to the limitation of virus diseases is not too distant. Similarly, one may comment that the outlook for chemotherapy of virus disease is not the hopeless one so commonly expressed.

SUMMARY

It is apparent that these comments have not sought to suggest all the important medical problems relating to virus infections. They are too numerous. Attention has been directed to the need to consider the role of viruses in producing diseases which may not become evident for extended intervals after infection or until physiologic or other disturbances bring them to activity. As a result the correlation between the initiation of virus infection and the clinical manifestation is not readily seen. Secondly, it has

been suggested that the complexity of the virus disease problem makes the immunologic approach to prevention and treatment less promising for total application than the chemical approach which current studies demonstrate to be possible and probable.

REFERENCES

1. Ackermann, W. W. Jour. Exper. Med., 1951, **93**: 337.
2. Brown, G. C., and Ackermann, W. W. Proc. Soc. Exper. Biol. and Med., 1951, **77**: 367.
3. Ackermann, W. W., and Francis, T., Jr. ADVANCES IN VIRUS RESEARCH, Vol. 2, p 81, 1954, Academic Press, New York, N. Y.
4. Ackermann, W. W. and Maassab, H. F. (in press)
5. Ackermann, W. W. Jour. Exper. Med., 1951, **93**: 635.
6. Ainslie, J. D. Jour. Exper. Med., 1952, **95**: 9.
7. Francis, T., Jr., Brown, G. C., and Kandel, A. Proc. Soc. Exper. Biol. and Med., 1954, **85**: 83.
8. Powell, H. M. and Culbertson, C. G. Proc. Soc. Exper. Biol. and Med., 1953, **83**: 161.
9. Cochran, K. W., Brown, G. C., and Francis, T., Jr. Proc. Soc. Exper. Biol. and Med., 1954, **85**: 104.

‹‹‹ ›››

Putting New Members to Work

Russell B. Roth, M.D., Erie, Pennsylvania

THE major trouble with the medical profession is that doctors are people. There would appear to be very few full fledged saints among us, complete with halos and a heavenly disregard for the material things of life. By fortunate counter-balance, I would say that there are equally few downright sinners in our ranks.

Today we are talking primarily about new members, and it has been my experience that the new doctor is, in general, a very superior sort of chap. By definition he is intelligent, else he could not have weathered his years in college, the competition for admission to a medical school, and the intellectual rigors of his medical education and internship. To top it off he had to pass some reasonably searching scrutiny to be licensed to practice his profession in his state. He is a veteran of a number of "commencements": high school, college, and the attainment of his M.D. degree. Actually each of these "commencements" was but the mark of a transition in the process of obtaining preparation and training for his real work in life. It is at the moment that he hangs out his shingle and applies for medical society membership and hospital affiliations he really is commencing that for which he has been spending all this time getting ready.

At this point in his career he is almost certain to be a youngster with high ideals. The things that "go wrong" with a doctor usually develop from that time on and seem to be in large part traceable to the newly introduced factor of economic competition. It is a high tribute to American medical education that the new-fledged doctor these days rarely can be adjudged incompetent. But he still is a person and there is no known guarantee that any person, confronted with economic stress, will react uniformly in an idealistic fashion.

If there is any deficiency in American medical education, it must be that while it is instilling into its pupil a wealth of technical and scientific information, and training his hands and eyes in the incredible skills of diagnosis and treatment, it is to a major degree neglecting to prepare him for the fact that there is a practice to be built, there are fees to be charged, intra-professional relations to be established, and a complex code of ethics to be learned and complied with.

Perhaps it is expecting too much to think that any medical school can offer much in the way of preparation for the individual and local problems that will confront the new doctor. Perhaps it is just as well to leave that phase of professional education to a more regionalized and more individualized faculty. If so, it must be at once apparent that the County medical society has a job which it must take seriously, since there seems to be no one else to do the job. The new

Presented at the 1955 Annual Secretaries' Conference, Springfield, Illinois, March 27, 1955.

doctor presents a problem in preventive public relations.

So much for this new member that we wish to put to work. Now let us think a little about the work that we wish to get him to do. County medical society work would be a bit difficult to break down into any set of job specifications. We have 33 committees, 8 offices, a board of Censors, a board of trustees, and an executive council in our society. All these jobs require work of some kind during the year, even if it be only the exercise of intellectual ingenuity in dreaming up an annual report for a committee that has done nothing whatsoever. The AMA has produced a small book which covers the solid core of proper county medical society activities, and it puts out a monthly newsletter documenting the new twists and turns that are continually being evolved over the country. The types of work that county societies have undertaken or may undertake is unlimited.

It is not amiss for us to generalize a little about the character of county society work. It has this common denominator—it is all unpaid. On the other hand, it is only unrewarding when it is useless work. In my own society we have had a few unhappy experiences, such as the time, six or seven years ago when we worked diligently to stage a series of public meetings designed to educate the public on common medical matters. We had the auditorium, the panelists, the usherettes from the auxiliary, and the appealing titles such as "Two Eyes for Life" and "Hope for the Heart". For the audience, we had a sprinkling of friends and relatives of the speakers, most of the members of the public relations committee, and a handful of dyed-in-the-wool hypochondriacs out shopping for fresh symptoms. Some of the people who worked the hardest on that project have been resting on their laurels ever since.

Then there was the time that we thought we needed a liaison committee with the pharmacists. They took a slightly uncharitable view of certain phases of physician dispensing and certain prescription writing habits of some of the brethren. We, in turn, grumbled a bit about occasional substitutions, inequalities in drug prices, and a few other pharmaceutical matters. So we unleashed on them a committee which went at its job, hammer and tongs—or mortar and pestle. That which emerged was a wonderful manifesto from the druggists announcing that at the behest of the Erie County Medical Society they had decided to issue a standarized schedule of minimum drug prices to overcome the medical objection to variable costs of standard items, and that henceforth the minimum charge for any prescription item would be seventy-five cents. They published this plan and we had to deny promptly that we had asked for any such thing. They barked back, and the upshot of the good offices of our liaison committee on pharmacy was a rupture of relations which would have been a strain on any truss.

Committee work, of course, can't always be productive. Committees seem to be part of the American way of life. One foreign visitor is said to have reported to his countrymen when he got back that if any 10 Americans had to bail out of an airplane they would form a committee and adopt a constitution and by-laws on the way down. To that I can only add that if it was a long drop they might also appoint a subcommittee to make a survey. That is a real good wheel spinner for any committee that doesn't know precisely what it has to do or how to do it. Carefully managed, the survey can occupy the whole year, leaving the committee at the end of its tenure with a fair idea of what ought to be done, and in good position to suggest that their successor ought to do something about it.

The fact is that much county society work is useless and therefore, unrewarding work. Worse than that it is discouraging work, breeding in those who have been committed to it the "to hell with it attitude". This is no kind of a job to give your new member.

With due deference to the blanket prescriptions for good public relations that have been compounded by the AMA and by the state and county medical societies, we must examine them carefully to be sure they are not placebos. If there are incompetent or renegade physicians among us, there is little value in a glib campaign to make out otherwise. If there are areas of grossly inadequate medical care in our particular spheres, we gain little by preaching the virtues of the free-enterprise American system, and the superiority of our infant mortality figures over those of the heathen Chinee. County society work which comes under the heading of camouflage work is unlikely to be appealing, and is

certain to create no sense of accomplishment.

Now, having been a bit dogmatic about the character of the new member, and the nature of the work to be done, I should like to comment briefly about the technique of introducing the one to the other.

Certain of your new members will have what commonly passes for a sense of civic responsibilities—you know the type—board of trustees of a dozen organizations, Community Chest, Cancer society, Chairman of the finance committee, inveterate speaker to PTAs and church circles. I stand before you as a living example of the species, and as an authority for the statement that usually this is far less evidence of a sense of civic responsibility that it is of a low titre of resistance against nominating committees and program chairmen. These fellows are easy. All one has to be sure about is that they are not ignored, that they are given an invitation to go to work.

In our society, at the preliminary meeting held between Candidates and our Board of Censors, all incoming members are given a listing of society committees and are told to indicate what committee or committees they would enjoy serving upon, and it is made mandatory that they choose at least one committee assignment. I think we may accept it as axiomatic that there is no shortage of individuals with the capabilities for the work of a medical society, but the trick is to persuade them to exercise these capacities.

There are certain traits in human nature, however, which can be well exploited in this good cause. The first is that every new doctor wishes people to know he is here. He may need a little assistance in doing his official announcing on an ethical plane, and the county society can help him by providing a proper mailing list for his announcements and in making suggestions for the provision of glossy prints to the newspapers. Our Press committee will do all this for him if he wishes. At the same time, we suggest to him that our speaker's bureau needs help. It is casually suggested that PTAs, church groups, and the like provide fine places for the young doctor to meet his public in an ethical manner. If he boggles a bit at plunging into a career of public speaking, we can always send him out with a film. For example, we have achieved a fair degree of coördination between our speakers bureau and the voluntary health agencies.

Requests galore pour into the Cancer Society for the film on Self-Examination of the Breast, and what better ice-breaking assignment could you give to the young surgeon who feels that he knows about as much as there is to know about carcinoma of the breast and chronic cystic mastitis. He can go along and show the film and then stand ready to answer questions afterwards. But he has to be briefed; on an assignment like this he has to be reminded that he is not being sent out to solicit patients. He is out to spread some information, and he is to put in some good words for the cancer society, and for the medical society.

On a subject like this he usually is advised to point out that the county medical society stands as a bulwark against quackery and charlatanism. He can deliver himself of a happy little speech on being chary of the promisers of sure and easy cures. He can suggest that if a person has questions about those who represent themselves as healers and cancer experts they may check the authenticity of the individual with the county medical society. I believe I can safely say that we have yet to be turned down by a new member for such a speaking assignment except on the grounds of a legitimate excuse concerning prior commitments.

The second trait of human nature which actually needs exploiting is the desire of the new doctor to establish himself on good terms with his fellow physicians. The nature of our committee meetings is calculated to capitalize on this. Insofar as possible, committee meetings are kept from being quick perfunctory affairs. The organization meeting of each committee usually is an evening affair scheduled at 9:00 p.m. so as to interfere as little as possible with evening office hours of general practitioners. Along about 11, the chairman brings out some sandwiches or cold cuts and a little spiritual replenishment. The ex-officio members, president, secretary, et al., are present to stimulate attention to the program of the committee until it has been well discussed and from then on the evening is social.

The problem is not to get people to attend such sessions, it is to get the die-hards to go home. Doctors are a gregarious group. The new

member, even in spite of any resolutions he may have made to be a silent onlooker, finds himself coming up with ideas and offering to do jobs. Our major committees and councils hold all their meetings in this fashion. They are pleasant and well attended sessions.

Exploiting this same basic desire of most individuals to be part of the group we have a bowling league which has been an invaluable help in introducing the new member to his colleagues.

Fundamentally it is our desire to impress upon the new member the value of the Society by a concrete demonstration to him of how it may be of service to him. I have spoken of assistance in getting out his announcements. It makes available to him health-accident and disability income insurance. It presses him into service on the emergency medical service, the civilian emergency flying squad, and we make a point of including him in at least one of our medical television presentations. Through the medium of our social affairs, Christmas and spring dinner dances with the auxiliary, mixed bowling sessions, and occasional regular sessions of the society to which the women are invited we endeavor to help the new doctor's wife, if he has one, become acquainted in the group. The auxiliary does the major part of that job.

We are a long way from being perfect in our techniques but we have felt well rewarded when we look down our list of committees and find the new members of yesterday acting as the chairmen of today.

‹ ‹ ‹ › › ›

Is this operation necessary?

What are the indications for hysterectomy? Have you asked yourself this question lately? With the present day indictments of the operating doctor by the lay press and even by members of our own profession, it behooves all of us to take stock and review the indications for hysterectomy. Most of the newspaper and magazine publicity reflects on unnecessary surgery. No doubt, there is still unnecessary surgery being done, but most hospitals are rapidly correcting this problem. On the other hand, I believe it is more important to evaluate the type of hysterectomy performed, in relation to the indications. That is, each patient must be individualized. Does she need a vaginal hysterectomy with repair, does she need an abdominal hysterectomy because of adnexal pathology, or will a combined procedure be necessary? *W. Powell Hutcherson, M.D., and Arch H. Bullard, M.D. Indications for Hysterectomy. J. Tennessee. M. A. June 1955.*

A strange epidemic

There is said to be a worldwide epidemic of plantar warts at present, affecting girls in the 10-12 year age group, and boys to a lesser extent. For some unaccountable reason, January, February, and March were the months of highest incidence. *Herbert Rattner, M.D. What's New and What's True of What's New in Dermatology. California Med. July 1955.*

‹ ›

Food and the liver

Chronic alcoholism of a degree sufficient to interfere with adequate intake of food is, on occasion, encountered in the aged but it is not as common a cause of vitamin deficiency as it is in the age groups in which cirrhosis of the liver occurs most frequently, i.e. the fifth decade in females and the sixth, in males. *Thomas E. Machella, M.D. Masked and Obvious Vitamin Deficiency States in Older Age. Pennsylvania M.J. June 1955.*

Alcohol Inhalation in the Treatment of Acute Pulmonary Edema in the Immediate Postoperative Period

RUTH WEYL, M.D., CHICAGO

THE appearance of pulmonary edema in a surgical patient denotes grave danger. Whatever the underlying cause, the emergency is supreme. The causes of pulmonary edema (whatever they are) must be severe to cause the acute episode, and the appearance of the pulmonary edema adds to the seriousness of the condition. A vicious circle is created by which the condition tends to become more and more severe due to the presence of the outpouring foam. The foam interferes with oxygenation and, the poorer the oxygenation, the more foam; the more foam, the poorer the oxygenation.

It has been known for more than 30 years that fairly large amounts of fluid can be tolerated in the respiratory passages as long as no foam is formed[1,2]. It is the foam that is so dangerous. Through the foam the volume of the air-fluid mixture increases and modified physical properties of the fluid lead to severe effects by blocking the small bronchi. Anoxia develops and is followed by higher pressure in the pulmonary artery and increased permeability[3,4]. This is why it occurred to Luisada[5,6,7] that if an antifoaming agent could successfully modify the surface tension in such a way as to decrease the foam, oxygen could get through, and the vicious circle would be interrupted. Thus in a series of experiments, promising antifoaming agents were tested, among others n-octyl alcohol, methyl-n-hexacarbinol (capryl alcohol) and 95% ethyl alcohol. Using adrenalin to produce pulmonary edema in rabbits[6], Luisada found ethyl alcohol vapor the most effective antifoaming agent, causing a survival of 90% of the animals for more than six minutes. The heavy alcohols decreased the severity of the edema and slightly increased the survival time, but the action of ethyl alcohol was far more marked than that of the others. These results were confirmed in the guinea pig, rat, and dog, using other methods of causing pulmonary edema[6]. By administering ethyl alcohol inhalation while edema was produced, the latter could be aborted. The next step then was to try alcohol inhalation in the human being[8] and most successful results were obtained in medical patients, as reported elsewhere[8,9]. Since then, others have reported good results with ethyl alcohol inhalation[10] and with 2 ethylhexanol[11,12,13] in acute pulmonary edema.

In this paper we are reporting seven cases of acute fulminating pulmonary edema directly following surgery which were treated with alcohol inhalation. Each attack was characterized by an outpour of large amounts of pinkish or yellow-tinged foam, and bubbling râles and rhonchi over the lung fields. The diagnosis was made by us and confirmed by the surgeon and/or the internist. In those cases where the P.E. was due to heart failure, the report of the ECG taken at the time will be given. All of these patients were getting oxygen when the attack of the P.E. started.

TECHNIQUE

The technique used is simple; the apparatus is available in every operating room. The wick-type ether vaporizer on the anesthesia machine used when the attack occurred was emptied of ether, the wick was dried and the jar filled with 95% alcohol. Oxygen was used for vaporization and the vaporizer was opened to full capacity.

From the Department of Anesthesiology, Mount Sinai Hospital, Chicago; and the Department of Surgery, the Chicago Medical School.

Associate Professor of Anesthesiology, The Chicago Medical School.

Presented at the Section on Anesthesiology, 115th annual meeting of the Illinois State Medical Society, May 7, 1955.

The closed circle absorption technique was used to be able to assist breathing whenever necessary. As it happened, this technique of alcohol vaporization had been evaluated in our preliminary studies on conscious patients[8], and it had been found that in all subjects mild euphoria and slight drowsiness occurred, with insignificant changes in pulse and blood pressure. The serum concentration of alcohol was found to be less than 10 mgr. per 100 cc. after thirty minutes of inhalation. Thus when we encountered our first case of pulmonary edema in the operating room we did not have to send for any special equipment but could start the alcohol inhalation immediately, 95% alcohol being available in the operating room.

For two of our patients who were already in the recovery room when the attack of pulmonary edema occurred, the standard equipment described by us for the use on the floors was available. A special type of vaporizer using the principle of jet atomization for increased saturation, and showing certain safety features[8], method II is used with 30% alcohol. The attached meter mask can be used with and without positive pressure.

There was no difference noted in the effects of the two methods of vaporization on the pulmonary edema. The latter method meets the demands of non-explosiveness and increased safety on the floor[14,15]. However, in the operating room where precautions are provided to use the much more explosive anesthetic agents and where experienced personnel handles the equipment, the anesthesia machine serves the purpose excellently.

CASE REPORTS

Case 1: S.W.-254502. This 61-year old patient was suffering from pyloric obstruction and was scheduled for gastric resection. Past history revealed exertional dyspnea and bilateral intermittent claudication after walking two blocks. When seen in the operating room, he appeared cooperative, not unduly apprehensive, and well-premedicated. His red blood cell count was 5,220,000; Hgb. 16.5 gm. and white cell count 12,000. An ECG taken the day before showed low voltage, T diphasic AVL, but was considered essentially normal. Induction of anesthesia was smooth and so was intubation. Balanced anesthesia with circle absorption technique was used and respirations were assisted. Pulse and blood pressure were satisfactory (B.P. around 140/80; pulse 100) and color was good. One pint of blood was given in 1½ hours. After the peritoneum was closed, only nitrous oxide-oxygen 50% was administered by the semiclosed circle-absorption technique. At the end of the three-hour operation it was discovered that a definite circumscript cyanosis was present involving the neck and upper chest. Several tentative diagnoses were made. Atelectasis could be ruled out and so could aspiration of solid material. The pulse at this time was 140. B.P. 100/60. A transinjected intravenously. Though the ECG taken preoperatively had been essentially normal, another tracing was taken in the O.R. While the electrodes were applied, sudden appearance of foam from the mouth was noted, and gurgling and bubbling noises were heard. Immediate inhalation of oxygen-alcohol vapor was instituted and within 20 minutes, not only the pulmonary edema had subsided and the chest sounded clear, but the color was pink and the patient seemed to be in much better condition. The ECG taken at the time of the episode showed changes suspicious of anterior wall infarct, and follow-up ECG showed definite acute anterior wall infarct. A white count taken on the first postoperative day showed 24,000 W.B.C. The B.P. in the recovery room, where the patient was observed for several hours following the cessation of the pulmonary edema, was maintained around 110/80. Pulse was 88. Patient was responding and the color remained pink. The patient was informed of the presence of myocardial infarct and treated for it. He made an uneventful recovery and left the hospital six weeks later in good condition.

The next episode happened in the Recovery Room: Case 2: Z.N.—239126. A 59-year old male gave a history of having had "a coronary" in 1941 and 1942. Ever since then he had anginal episodes, occasionally requiring nitroglycerine for relief. He had been treated in the Hospital at the beginning of 1953 for coronary insufficiency, partial A-V block, and recent anteroseptal infarct. He had been treated with digitalis, nitroglycerine, and sedatives, and had recovered. Seven months later he was readmitted for the operation of a carcinoma of the rectum. Rectal bleeding had been present for two weeks. He had symptoms of severe angina pectoris and chronic coronary sclerosis, and pronounced emphysema of the chest.

Under balanced endotracheal anesthesia, he was doing well during the 3½ hours of abdomino-perineal resection. Blood pressure was maintained at 120/68, 110/70. Pulse 76. He was given 1000 cc. of blood which was considered adequate replacement for the amount of blood lost. He left the operating room in apparently good condition. In the recovery room, oxygen was given by mask as a routine procedure and suction used when needed. Glucose in water was given intravenously very slowly. Suddenly, about one hour after the operation, he became restless and dyspneic; the nails and lips became very cyanotic. Pulse was irregular, hardly palpable. On auscultation, râles and rhonchi were heard all over the chest and suddenly foam started pouring out of the nose and mouth. Acute pulmonary edema was diagnosed. Administration of alcohol-oxygen was started at once and 3¾ gr. of aminophyllin were injected intravenously. Within 20 minutes, the condition cleared up completely. One

hour later, pulse was 84, of good quality, color and respiration adequate. The next three days he was suffering from gastric dilatation and on the sixth postoperative day, he had another acute episode of cyanosis and dyspnea, but no pulmonary edema. The ECGs showed evidence of an acute posterior wall infarct. Digitalis was given and he seemed to be doing well, except for constantly considering suicide, until six weeks later when he died—apparently from a new infarct. There was an attempt to supply alcohol-oxygen treatment for the final fulminating pulmonary edema, but only about one hour after the onset of the condition and after everything else had been tried. Ten minutes later he was dead. There was no post-mortem examination.

Case 3: J.W. — 256039. A 78-year old male, was suffering from a perforated cecum due to carcinoma with spilling of fecal contents. Following an exploratory laparotomy and exteriorization of the cecum, he showed signs of respiratory depression and delayed awakening. The endotrachael tube was left in place, and respiration was assisted for several hours, 100% oxygen being given. Towards the end of this time, assistance to respiration became exceedingly difficult. The patient suddenly became cyanotic; the blood pressure dropped and the pulse became imperceptible; gurgling sounds were audible and foam began to pour out through the endotracheal tube. Levophed had been given intermittently before this episode and was promptly started again. Alcohol-oxygen vapor was administered after suctioning the trachea briefly. One-half hour later both lungs could expand adequately, the edema had ceased completely and the color improved. A very short time afterwards respiration seemed adequate, the endotracheal tube could be taken out and when the patient awoke a little later, he was mentally clear and seemed in reasonably good condition. An ECG taken two days later showed a fully developed anterior wall infarct. In the next two days an overwhelming peritonitis and jaundice developed, and the patient died three days after the operation from the surgical complications of a perforated cecum.

Case 4: E.E. — 218384. This 37-year old colored patient had to undergo a total abdominal hysterectomy for a huge irregular mass in the abdomen. Since she was suffering from asthma, spinal anesthesia was chosen. About 50 minutes after the spinal anesthesia had been given and while the patient was in steep Trendelenburg position, the anesthetist thought he heard wheezing in the patient's chest and started aminophyllin and 25 mgr. of Demerol intravenously. Ten minutes later, the patient suffered a cardiac arrest. She was resuscitated by cardiac massage, while artificial respiration was maintained through an endotracheal tube, and the operation was completed. Spontaneous respiration was resumed shortly afterwards. The patient was placed in an oxygen tent. Concentrated plasma was administered repeatedly but there was no sign of regaining consciousness. Four hours after the operation, the pulse suddenly became very fast (130), and scarcely obtainable. The patient became cyanotic and fulminant pulmonary edema developed which cleared up completely after administration of alcohol-oxygen for 20 minutes. Several hours later the patient started to have convulsions and although every therapeutic effort was made, the patient died in coma, 42 hours after the operation. The postmortem examination showed cerebral edema, bronchopneumonia, atelectasis and some residual pulmonary edema, which apparently developed in the agonal stage. No effort had been made to combat it at this time.

Case 5: The next patient, S.B.J. — 256611, a woman of 47 was operated upon for mitral stenosis. Her pulmonary pressure was very high. The operation was completely uneventful, but on the second postoperative day, the patient exhibited fulminant pulmonary edema, in spite of adequate digitalization. Immediate treatment with alcohol-oxygen vapor using the Heidbrink anesthesia machine with some assistance on inspiration proved successful and complete recovery ensued.

Case 6: This 40-year old woman, M.Z. — 243441, too, was operated upon for mitral stenosis. She too had a high pulmonary pressure, preoperatively. Shortly before closure, while ethylene-oxygen was administered in a 50% mixture, the surgeon remarked that the lung felt very heavy. A few minutes later gurgling sounds were heard through the breathing tube and immediate suction through the endotracheal tube revealed foaming sputum. Instant alcohol-oxygen administration was started with complete success. The foam subsided and the operation proceeded. The ECG taken at the time showed ventricular extrasystoles and quinidine gluconate was administered in divided doses (0.6 gm. and 0.4 gm.). The patient made an uneventful recovery.

Case 7: A 34-year old obese colored patient, F.B. — 258487, was scheduled for postpartum sterilization for multiparity (8 living children). She had been coughing for some days before delivery. There was no history of asthma or of allergy. Chest was essentially negative. Blood pressure was 110/80, pulse 80, good quality and regular. Hgb. 13.1 gm. WBC 11,000. Premedication consisted of Demerol 100 mgr. and atropine gr. 1/150 one hour before operation. There was some coughing during the induction with pentothal sodium (500 mgr.) and apparent obstruction as soon as cyclopropane had been started. The insertion of a pharyngeal airway to relieve the obstruction was followed by more coughing and cyanosis. Deepening the anesthesia with more sodium pentothal, and the use of 40 mg. succinylcholine and assisted respiration restored the patient to good color. The operation proceeded uneventfully. However, on awakening, the patient started to cough violently and became quite cyanotic. Breathing was labored, the abdomen was pushed out and the chest drawn in with each breath. Expiration was prolonged. On auscultation, breath sounds could barely be heard over the right middle lung field. A nasotracheal airway was inserted to allow for adequate suctioning of the right bronchus, since atelectasis due to a mucous plug was suspected. However, if there was a mucous plug, it could not be dislodged by either suctioning or coughing. The obstruction was not re-

lieved and the chest could not be inflated adequately. Atropine gr. 1/150 was injected intravenously since it seemed obvious that some bronchospasm existed and the endotracheal tube was withdrawn as it increased coughing without beneficial results. After withdrawal of the tube bleeding from the nose was noticed, which, due to the strenuous coughing assumed frightening proportions in a matter of minutes. Coughing and bleeding increased and cyanosis was present in spite of administration of oxygen. Breathing was labored. A nose and throat specialist was summoned to judge the severity of the bleeding and to insert a postnasal pack if deemed necessary. When he arrived a few minutes later, the picture was much clearer. Pinkish foam was pouring out from nose and mouth, and gurgling sounds were heard. He examined the nose and declared the bleeding not of major proportions. The general impression now was that the pulmonary edema was our main concern and had to be treated first. Alcohol vapor inhalation was started immediately with most dramatic effect. Within four minutes, the coughing had stopped, the bleeding stopped, and the patient was breathing quietly without effort. The color became good. Alcohol vapor inhalation was continued for another ten minutes, until clear breath sounds were heard over both lungs. The patient left the operating room wide awake and in good condition. Two factors had apparently favored transudation of fluid into the alveoli: 1) The anoxia which increased the pressure in the pulmonary circulation and the permeability of the pulmonary capillaries, and 2) the Trendelenburg position in an obese patient with distended abdomen, which decreased the vital capacity of the lungs and increased the pulmonary blood flow. The labored respiration and even more so the violent coughing churned the fluid into foam. Postoperatively pulse rate and color of the patient remained good, but the blood pressure fell to 87/70, 76/50 and stayed so for several hours in spite of administration of levophed. An EGG taken in the early afternoon was normal and so was a chest plate. The chest was normal on auscultation and percussion; breathing was quiet and unobstructed. On the third postoperative day, the patient developed a contact allergic dermatitis which reacted promptly to antiallergic treatment. She made an excellent recovery.

DISCUSSION:

Seven patients who exhibited acute pulmonary edema of different origin in the immediate postoperative period were treated with alcohol inhalation. Three patients had suffered acute myocardial infarcts; two patients were operated upon for mitral stenosis; one incident happened after resuscitation for cardiac arrest and one was due to respiratory obstruction. In all seven patients the response to the treatment seemed dramatic, the outpour of foam stopped, the color improved, and the acute suffocation due to oxygen want could be avoided. All seven patients were receiving oxygen when the pulmonary edema started; therefore, the success of the therapy seems to be attributable to the antifoaming action of the alcohol. There were no fatalities during the attack in this series. Four of these patients left the Hospital in good condition; one patient did well for another six weeks (case 3), two patients died within three days after surgery, one of fulminant peritonitis, the other because of cerebral edema (case 5). Two of the patients again developed pulmonary edema later (case 3 - 6 weeks later and case 5). No efforts were made in case 5 to supply alcohol inhalation at this time for obvious reasons, and in case 3 the effort was belated. The success of the method seems to be based on an early institution of the treatment. It can be combined with any other treatment deemed necessary. There seems to be no contraindication inherent in the condition of the patient.

SUMMARY:

Seven cases of acute pulmonary edema of different origin have been encountered in the immediate postoperative period within the last four years. The case histories are presented. All seven patients responded dramatically to alcohol vapor inhalation. The success in this series seems to be based on the early institution of the treatment. Since there seems to be no contraindication to the use of alcohol vapor inhalation and since it can be combined with any other treatment, it is recommended to use alcohol vapor inhalation during surgery or in the immediate postoperative period whenever there is incipient or fulminant pulmonary edema, and even when there is only a suspicion of beginning pulmonary edema.

BIBLIOGRAPHY

1. Laquer, E. and DeVries, Reilingh: Die Klinischen Erscheinugen bei Künstlicher Füllung der Lunge mit Flüssigheit und bei Osmotischem Lungenodem. Arch. f. Klin. Medizin. 130: 310 (1919).
2. Laquer, E. and DeVries, R.: Perkussion, Und Auskultation am Normalen Kaninchen und Nach Erzeugung von Osmotischem Lungenoedem als Hilfsmittel beim Propadutischen Unterricht, Zentralblatt für inn. Med. 41: 81, 1920.
3. Von Euler, U. S. and Lilienstrand, G.: Observations on the Pulmonary Arterial Blood Pressure in the Cat. Acta. Phys. Scand. 12: 301, 1946.
4. Drinker, K. C.: Pulmonary Edema and Inflammation. Cambridge Howard Univ. Press, 1947.
5. Luisada, A.A.: Therapy of Paroxysmal Pulmonary Edema by Antifoaming Agents. Proc. Soc. Exp. Biol. and Med. 74: 215, 1950.
6. Luisada, A.A.: Therapy of Paroxysmal Pulmonary Edemaby Antifoaming Agents. Circulation 2: 872, 1950.
7. Luisada, A.A.: The Mechanism and Treatment of Pul-

monary Edema. Illinois Med. J. 100: 254, 1951.
8. Luisada, A.A., Goldman, M.D., Weyl, R.: Alcohol Vapor by Inhalation in the Treatment of Acute Pulmonary Edema. Circulation 5: 363, 1952.
9. Goldman, M.A. and Luisada, A.A.: Alcohol-Oxygen Vapor Therapy of Pulmonary Edema. Ann. Int. M. 37: 1221, 1952.
10. Gootnick, A., Lipson, H.K., Turbin, J.: Inhalation of Ethylalcohol for Pulmonary Edema. New England J. Med. 245: 842, 1951.
11. Reich, N.E., Rosenberg, B.A., Metz, M.: A New Therapy for Acute Pulmonary Edema. N.Y. State J. Medicine 52: 2647, 1952
12. Reich, N.E., Rosenberg, B.A., Metz, M.: The Use of 2-Ethylhexanol in Acute Pulmonary Edema. Dis. Chest 23: 43, 1953.
13. Reich, N.E. and Rosenberg, B. A.: The Combined Use of Intermittent Positive Pressure Oxygen and 2-Ethylhexanol in Acute Pulmonary Edema. Am. Practitioner Dig. Tract. 4: 616, 1953.
14. J.A.M.A. Editorial Vol. 154: 62, 1954.
15. Luisada, A.A., Goldman, M.A., Weyl, R.: Alcohol-Oxygen Vapor in Pulmonary Edema (correspondence). J.A.M.A. 155: 62, 1954.

« « « » » »

The Thermonuclear Fall-Out Problem in the State of Illinois

Charles L. Maxwell, M.D., Chicago

RADIOACTIVE fall-out is a thermonuclear problem which can cause great distress over large areas of the State of Illinois, producing much sickness and destroying some lives. This, in addition to the heat and blast effects of a hydrogen bomb, would seem to make the task of casualty care and prevention of radiation reactions the most formidable problem confronting health authorities at this time. Today I am going to speak on the subject of radioactive fall-out and in this field, I assure you, something can be done about it. The answer is not simple and the effort required in producing preventive and post-bombing protection will require considerable time and effort on the part of many people.

A great deal of the difficulty in recognition of the problem stems from the rapidity of change from the development of the atomic bomb dropped over Hiroshima to the development of the thermonuclear weapon in 1952 and the discovery of the potential danger of radioactive fall-out in the test of March 1, 1954. Heretofore, the American people had roughly a generation to absorb the major changes in military weapons but here in the short space of ten years, we find three major changes taking place, each as never before affecting the population as a whole. No wonder the average citizen, unfamiliar with thermonuclear technicalities, is in a high state of confusion. Radioactive fall-out information should be as generally known as that of simple first-aid, home sanitation, and communicable diseases. I shall attempt to give you that information today, leaving out as much technical data as possible, and presenting the material in a form you may desire for presentation to your home audiences.

Two years ago you were told that in an atomic bomb air burst, except for the immediate radiological reaction coming with the burst, the fall-out would be negligible in character. Why is it then that with the hydrogen bomb, which is a thermonuclear device, there should be so much difference? The explanation is simple. In the average atomic bomb, the fireball probably would have little more than a diameter of 1 to 1½ miles so that a burst 1,000 to 6,000 feet above ground or higher would not disturb the surface earth to any extent. With the hydrogen bomb, the fireball will have a 3 mile plus diameter and this brings the altitude level at which it must be dropped, to be a true air burst, at between 15,000 and 25,000 feet above the earth.

Remarks delivered by Dr. Maxwell, as Deputy Director for Health, Illinois Civil Defense Agency, at a meeting of Central Illinois Civil Defense Directors, Springfield, Illinois, March 20, 1955.

It would appear not practicable to detonate a bomb of that type at that level since the airplane carrying it would have to be at least twice that height for crew safety. Therefore, it would appear that all hydrogen bombs will be dropped at a height where the fireball will, at all times, have more or less contact with the ground. In the hydrogen bomb detonation there will be considerable ground debris material drawn up into the thermonuclear cloud from which the ground debris receives its radioactivity. Since the hydrogen bomb has such greater destructive power than the atomic bomb, it can be expected to be used as a partial ground burst weapon.

AREA OF FALL-OUT

The area of fall-out from a hydrogen bomb detonation will depend a great deal upon weather status at the time of detonation; and the intensity of the fall-out would be subject to considerable fluctuation depending upon the intensity and quality of mixture of ground debris in the bomb cloud. Experience today indicates that the average fall-out would be roughly elliptical in nature, having a maximum width of about 40 miles and a distance of about 200 miles, with the greater intensity of the radioactive material being in an area with a width of 20 miles and a distance of 140 miles.

It would be fine if weather and winds were standardized, permitting us to make advance predictions of the fall-out pattern. There was a time when most people felt that the winds aloft, that is between 20 and 40,000 feet, were almost 100 per cent from west a little north to east a little south. However we find today that, for the purposes of accurate information of the hydrogen bomb radioactive fall-out potential, the variance of all winds is such that we must have six-hour weather reports to be reasonably certain of knowing, within reason, the fall-out pattern.

The U. S. Weather Bureau is doing a magnificent job preparing statewide and nationwide necessary weather data. This will greately assist in combating the radioactive fall-out problem through advance warnings of the probable path of winds and clouds carrying the radioactive debris.

INDIVIDUAL HUMAN AND ANIMAL PROTECTION

Dr. Ralph E. Lapp in a recent article in the Bulletin of the Atomic Scientists, gave the following example of the hazardous problems facing individuals as follows:

"Assume that Mr. A., still alive following a hydrogen bomb attack, is panicked and walks or runs all day, spending 9 hours in the radioactive fall-out area before finally reaching a noncontaminated place or before someone forces him to take shelter. From this exposure he might get a dose of 930 roentgens — 1½ times more than a deadly dose of about 550 r. His panic or his ignorance would have cost him his life.

Consider now the case of Mr. B, still alive following an H bomb attack, who is alerted by the thunder-clap of the explosion or information from his local Civil Defense Director and, being out of blast damage range, seeks shelter. A prudent man, he has prepared a simple basement shelter to which he takes his family and food and water to last for seven days. After two days he emerges, receives such advice on his battery-powered radio as will come from his Civil Defense Director or local radiological monitoring team and then either stays put for a longer time or travels to a safe area. He will have received very slight radiation while sheltered. In traversing the contaminated area after two days he could go a full day without radiation injury.

These two cases illustrate that the maximum peril from fall-out is concentrated in the first day; or in the most heavily contaminated area, in the first two days. This does not mean that the danger has vanished, for one still has to contend with the remaining part of the radiation. But since this is delivered more slowly over a period of weeks and months, it is not an acute hazard. This does not mean, however, that it can be disregarded."

The fundamental role of survival in radioactive fall-out is "get below the surface of the earth" — a basement under a multi-story house, the fruit cellar of a farm house, or simply any hole in the ground. If no emergency shelter is available and time does not permit digging a foxhole, one may seek second-class protection in a structure like a barn or one story house. Having a roof over your head, even though your head is not below the earth's surface, affords protection from direct contamination by the dangerous particles themselves. By keeping radioactive debris from touching the body, one eliminates the hazard of the short-range beta

particles which would otherwise cause beta-burns on the skin.

With reference to inhalation hazard in the radioactive-fall-out, the present unclassified information is insufficient to base a realistic evaluation. However, experimentation is going on in this field and later reports will follow. Needless to say, it is desirable not to inhale any of the radioactive material. Any simple type of nose mask, such as folded gauze or even a folded handkerchief is better than nothing. Clothing covering all parts of the body should be worn at all times in a suspected radioactive fall-out area. A good heavy coverall, a wide-brimmed heavy hat, rubber boots, and fairly heavy gloves will give a great deal of protection in any fall-out. These should be worn during any short emergency period wherein it might be necessary to go, for a short period of time, into some contaminated area; for instance, to drive stock under cover of a barn or other shelter. When emerging from a contaminated area, the boots or shoes should be thoroughly washed off and the protective clothing left outside the house.

Let me assure you that Civil Defense authorities from the Federal Civil Defense Administration on down are staggered, by this new development. The rapidity of change from the knowledge gained at Hiroshima to the radioactive fall-out problem has left many of us almost as confused as you yourselves. To have three radical changes in new weapons within a decade would seem almost too much for any one to bear.

This radioactive fall-out problem in no way minimizes the need for dispersal programs in urban areas but only adds additional problems to the heretofore main objectives of saving lives from blast and heat. Shelter, formerly, except in metropolitan areas, was not considered too necessary. It is now of prime importance throughout any potential radioactive fall-out areas. It is good advice to suggest that all new construction, whether for industry, government, or for homes, consider the needs for protection from radioactive fall-out wherever erected. Each industrial plant should be prepared to shelter all of its worker force for at least several days in a radioactive fall-out emergency.

EDUCATION

A carefully planned and well implemented program of thermonuclear education on the facts of radioactive fall-out survival should be conducted in every community. Radioactivity is a kind of mystic subject understood by less than .1 per cent of our population. It must be translated into simple language, simple demonstrations, and simple test drills. The scientist who has comparatively easy comprehension of the atom must realize the terror this "invisible killer" holds for the non-scientist and the recognition of this problem should be reduced to levels capable of assimilation by the average citizen.

RADIOACTIVE FALL-OUT MONITORING

Since one cannot predict accurately the fraction of radioactivity in fall-out because of the uncertainty of the size and quantity of particles in the debris sucked up into the fireball, monitoring, both air and ground, is of utmost necessity. This uncertainty in degree of fall-out would persist, regardless of possible classified secret data, because of climatic wind and weather changes which cannot be determined in advance for more than the six hour period. Not all radioactive particles come to earth in the fall-out with which we are concerned. Some fall back in the fireball crater area and much is carried on such tiny particles that they traverse the world without descending; however, it is certain that sufficient particles will always fall to create serious situations in some areas.

The ideal radiological monitoring team and the type which is recommended by the Federal Civil Defense Administration and the Illinois Civil Defense Agency is a team composed of six persons:

1 Captain (trained in monitoring technics and evaluation)

2 Meter Readers (trained in 20 hour course)

3 Aides [1 radio trained and 1 instrument repairman and 1 chauffeur and messenger

The air reconnaissance team will consist of the aircraft pilot and one or two members of a ground team, depending upon the size of the aircraft and the need in the main monitoring problem.

The primary function of the air monitoring teams will be to locate the boundaries of the fall-out areas, determining their total width, total length, and degree of intensity. The primary function of the ground monitoring teams assigned to area survey work will be to locate

and determine the boundaries of areas that were dangerously contaminated. Ground survey teams also will be responsible, where persistent residual radiation exists, for keeping a record of radioactive decay during succeeding hours and days. From these records the teams will determine boundary changes of contaminated areas with the objective of releasing areas for occupancy as soon as their radioactivity drops to a safe level. Other monitoring teams will be assigned to fire fighters, rescue teams, first-aid teams, and engineering teams. Their activities are centered in the area of heat and blast destruction and will not be discussed in detail in this paper.

SPECIAL EQUIPMENT AND SUPPLIES

Various items of special equipment and supplies will be needed by radiological defense personnel required to go into areas potentially contaminated. Suitable clothing will be needed to prevent contamination of the skin. Hard-covered hats or helmets, coveralls, gauntlet-type gloves, washable overshoes, and protective face masks should be available for all persons on the monitoring teams.

Every monitor should have a good compass, since survey work might be necessary at night; also in areas of heavy destruction where sense of direction might be difficult to maintain. Each man also would need a good flashlight of the type that clips to the belt or an equivalent type that need not be held in the hand; he should also have a pocket notebook and pencil. Because of radioactive decay, the time of reporting will be important. Hence, a good timepiece will be necessary.

Each monitoring team should have portable means of transmitting information to the radiological plot center. Depending on the communications system worked out by each local civil defense agency, walkie-talkie radio sets or the radio hook-ups used by the police service might be employed. Telephone lines would be used when functioning; and messengers when all communications are out.

MAINTENANCE AND INSPECTION LABORATORIES

The number of instruments that will be required to adequately and efficiently provide protection information for the citizens of Illinois is about 1600. Radiological instruments are not foolproof. They require reasonably careful handling, and at least yearly maintenance inspections and care. This will necessitate the development of sufficient radiological defense laboratories in Illinois to provide that service. Plans are being developed toward that end and this information should be available within the next 90 days.

TRAINING

A nucleus of trained monitors is available in Illinois at this time. Plans are being developed to expand this service so that, as instruments are purchased and teams organized, instructors will be available to carry out the training program necessary for good team training.

COST

The cost of monitoring instruments for 1,600 teams would be about $200,000, one-half of which probably can be made available under the Federal Civil Defense Matching Funds program. The maintenance cost of the radiological defense laboratories could probably be held to about $12,000 yearly per laboratory if they are installed within the framework of institutions operating in the State today. To summarize:

1. At the first notification of "fall-out" in your area, seek the best shelter available. This can be a house or basement or foxhole—all will provide some degree of protection. However, the best type is an underground space having 3 feet of earth overhead.

2. Stock shelter with food and water for seven days, utensils for sanitation, change of clothing, and a battery-operated radio for reception of Civil Defense information.

3. If contamination of clothes is suspected, change all outer garments after leaving a contaminated area and before going into your house.

4. Bathe your body thoroughly to remove any radioactive waste.

5. If your shelter is in a house or basement, keep all windows, doors and fireplace dampers closed; shut off ventilating fans and air conditioners bringing in outside air. Avoid letting outside air enter shelter unless it is effectively filtered.

6. Avoid tracking contaminated materials into the house or shelter.

7. Launder contaminated objects in special buckets or tubs.

8. Watch out for contaminated food after ground or water bursts.

9. Be sure water used after bombing is safe

before drinking by either humans or animals. All surface water will be contaminated but water from the average driven well, pumped out carefully, should be potable.

10. Remain in shelter until told by local monitoring teams or your local civil defense organization that it's safe to come out. Preparations should be made to stay in shelter as long as 7 days.

11. Join your local Civil Defense and learn how to survive under H-bomb attack.

In closing, let me remind you of our American heritage—you today are not facing, in proportion, any greater damage than our ancestors faced in New England; faced at Valley Forge; faced in the settling of the Ohio River Valley; and faced in the progress through the western territories. They met their difficulties with fortitude and courage and many died before victory was theirs.

Today with the same courage and fortitude we can meet this problem of our generation and, with the same determination to win, we are certain of complete victory.

‹‹‹ ›››

Missed Abortions

Harold E. Smith, M.D., F.I.C.S., F.A.C.S., Maywood

MISSED abortions refer to a fetus that has been dead for at least two months, and the patient has not been in labor or expelled the products of conception. Review of the literature shows the subject to be somewhat neglected. This pathological entity is much more common than textbooks indicate. Moreover, a proper understanding of treatment is of paramount importance.

Lubin and Waltman,[1,2] Cosgrove,[3] and Fisher,[4] all advocate conservative treatment. Eastman[5] and Hefferman,[6] independently reviewing Fisher's article, are in accord.

Hefferman[6] added that an occasional patient is disturbed because she is carrying around a dead baby. Reviewing our few cases, we find that practically all are disappointed, fearful, and mentally disturbed and these emotions are aggravated by the attitude of relatives and well meaning friends. The belief is common that the patient will be poisoned or otherwise harmed by the dead fetus. Fear and mental confusion may reach an almost uncontrollable state unless the physician recognizes and corrects the woman's apprehension. Many such patients change from one doctor to another until nature intervenes or their fears are allayed. Others may persuade the physician to use methods that are against accepted principals and his better judgment.

Fisher[4] reports morbidity of 18 per cent with forceful induction. Lubin and Waltman[1,2] report that surgical interference was responsible for the only deaths in Brooklyn from missed abortions. They believe that surgical evacuation may be complicated by hemorrhage, infection, perforation, or forcible tearing of an undilated and rigid cervix. Bleeding or other complications warranting normal interference are not included in this discussion.

After the death of the fetus, the suspicion that all is not well is recognized early by the patient and may be confirmed by the physician within one to three weeks. It is this early period — from the recognized death of the fetus to the arbitrary two month period for statistical missed abortions — that is of the greatest interest and concern. Proper diagnosis with treatment would prevent many women from going into this two month period.

From the Dept. of Obstetrics and Gynecology, Univ. of Illinois Medical School.

The exact etiology and explanation for failure to go into labor has not been established. Fisher[4] believes the fetus dies and the inner Langhan layer of the villi degenerate first but the outer, or syncytial layers, are constantly bathed in maternal blood. The slow atrophy of these cells apparently is not adequate in itself to produce the hormonal changes needed to initiate labor. Jeffcoate[7] states that there is a gradual drop in estrogen and progesterone levels in these cases. Von Graefe[8] about 40 years ago, thought the reason for missed abortion, was absence of normal uterine irritability which would cause expulsive contractions.

Diagnosis of fetal death, especially in early pregnancy, may be difficult. Uterine and abdominal enlargement may fail to continue or even diminish and retrogressive changes in the breast may occur. Trout and others believe that vaginal cytology is helpful. There is persistence of the modified pyknotic pregnancy type of navicular cells; abnormal cornification is maintained but with absence of numerous outer basal layer cells; mucus is minimal and leucoytes are few. Negative pregnancy test is helpful but not diagnostic; lower estrogen and progesterone levels are suggestive. After the fourth month, loss of fetal movement, heart tones, and X-ray findings offer additional signs.

After diagnosis is made the problem should be presented tactfully to the patient and her husband. Assurance must be given that a duplication of this type of abortion is rare. The couple should be assured that with frequent checkups and complete cooperation between patient and physician, no harm will follow the missed abortion, particularly with conservative management.

Conservative treatment means no surgical interference; it does not mean that medical treatment is contraindicated as there is a moral obligation to attempt medical induction of labor. Jeffcoate[7] and others believe that labor will not begin without administration of estrogen or the return of the menstrual cycle with estrogen. However, the regular use of estrogen has not insured labor. Pituitrin in the form of pitocin drip merits a try. In a small series, encouraging results were obtained with estrogen or stilbestrol, given in daily doses for 7 to 14 days, followed by pitocin drip if necessary. This could and should be repeated when necessary. When spontaneous or medically induced labor occurs, the uterus has then assumed its normal tone and contractibility and the unfortunate entity is terminated in the safest way. Vaginal hysterotomy or curettage should be reserved for the unusual case such as progressive bleeding anemia, increased blood pressure, or any other obstetrical emergency.

The physician must realize that in missed abortion, he has the responsibility of the mental as well as the physical health of the patient. He must educate and assure her that no harm will come to her, even though the fetus is dead and as yet undelivered. She must be convinced that conservative treatment is the safest.

BIBLIOGRAPHY

1. Lubin, S & R. Waltman. Missed Abortion. Am. J. Surg., (Feb.) 1949 77:202-207.
2. Lubin, S. & R. Waltman. Missed Abortion. Am. J. Obst. & Gynec. (Jan.) 1943-45. 89-95.
3. Cosgrove, R. Missed Abortion. Bulletin Margaret Hague Maternity Hosp. 7:3 (Sept.) 1954. 70-71.
4. Fisher, John J. Missed Abortion. J. Am. Acad. Obst. & Gynec. 1:5 (May) 1953. 529-534.
5. Eastman, N. J. Obst. & Gynec. Survey. (Oct) 1953. 524.
6. Hefferman R. Comments on Dr. Fisher's Article. Obst. & Gynec. J. of A.A. Obst. & Gynec. 2:4 (Oct.) 1953. 431.
7. Jeffcoate, T.N.A. Lancet 1:1045, 1940. T.N.A. Proc. Roy. Soc. Med. 43:734-737 (Oct.) 1950.
8. Von Graefe, M. Ueber Retention des manschlichen Eies im Uterus nach dem Fruchtod. Arb. a.d. Geb. d. Geburtsh. u. Gynaek. z. Feier. . . v. Carl Ruge, Berl., 1896. 38-79.

Newer Concepts of Diseases of the Gastro-Intestinal Tract

H. Necheles, M.D., Chicago

Dr. Samter: The progress of medicine has always relied on two groups of investigators: (1) men of imagination who had the curiosity, the initiative, and the sudden inspired guess which throws light into a darkness, and (2) the faithful workers who lay brick on brick and check the guesses of their contemporaries.

Since Beaumont, gastrointestinal physiology has been the field of imaginative individuals who were able to visualize the correlation between structure and function. Some of their ideas have been discarded. None, however, has failed to stimulate thought and research. It gives me great pleasure to introduce to you Dr. Heinrich Necheles, who is in charge of one of the most active gastrointestinal laboratories in this vicinity.

Dr. Necheles: I welcome the opportunity to present to you a series of concepts about selected phases of the physiology of the gastro-intestinal tract—about its role in fluid and electrolyte balance, about the absorption of foods, the changes in digestion and absorption with old age, about the absorption of "toxins" from the gastro-intestinal tract, and about a few observations which might add to our understanding of its function.

The Gastrointestinal Tract in Fluid and Electrolyte Balance

The digestive tract plays a major role in maintaining food and electrolyte balance. Normally, most of the secretions and most of the ingested fluids are absorbed. With these absorbed fluids important electrolytes, minerals and proteins return to the body and are utilized again. If fluids are lost by vomiting, by fistulas, or by diarrhea, serious disturbances can develop. With vomiting, large amounts of chloride can be lost, leading to alkalosis. Recently, it has been found that large amounts of potassium can be similarly lost, and water, chloride, and potassium have to be replenished quantitatively. Loss of potassium is followed by gastrointestinal atony and distention. Loss of fluid from intestinal fistulas or in diarrhea involves the loss mainly of alkaline constituents and encourage acidosis. Protracted diarrhea causes the loss of large amounts of proteins which may have to be replaced. In all of the above described conditions, the often enormous loss of water may lead to serious dehydration.

Director, Gastrointestinal Research, Michael Reese Hospital, Chicago, Illinois.

Absorption of Foods

Simple sugars like fructose, galactose, and glucose, are absorbed rapidly. Although it is not proved, it is highly probable that these sugars are absorbed so rapidly because they are phosphorylated in the intestinal mucosa. Sugars with larger molecules like rhamnose, arabinose, etc., are absorbed slowly, and apparently they are not phosphorylated.

The absorption of fat has been of considerable interest to us. Most fats become emulsified, with a resultant increase in surface on which the lipase can act. Some fat, however, is absorbed as such, without being split. The proof of this is that one can find in the blood, by dark field microscopy, tiny fat particles, 0.5 microns or less in diameter called chylomicrons. If these particles are counted in a constant area, the value obtained correlates fairly well with the chemical determination of blood fat.

SEMINAR
of the
DEPARTMENT OF MEDICINE
of the
UNIVERSITY OF ILLINOIS

Edited by:
Max Samter, M.D.
Associate Professor
of Medicine
Marvin J. Colbert, M. D.
Instructor in Medicine
Alexander P. Remenchik, M.D.
Clinical Instructor in
Medicine

We have demonstrated that bile and pancreatic juice are not essential for the absorption of fat. Our method was this: we isolated a segment of jejunum in animals (so-called Thiry loop) so that neither bile nor pancreatic juice could enter it. We introduced olive oil or oleic acid into the loop. Chylomicrons were found in the blood—approximately ¾ as many as when the experiment was repeated with bile being added to the olive oil.

It has been known for a long time that fat is excreted into the intestines by an active process of secretion or excretion. In isolated and sterilized loops of intestine, large masses of fatty material are found, consisting largely of neutral fat and cholesterol. We have examined the mechanism of fat excretion and we have found that it occurs in the form of tiny particles, similar to chylomicrons, and we have named these particles enterolipomicrons. Most of the lipid excreted into the intestine seems to be reabsorbed. The physiological purpose of this process is not known.

When the normal physiology of the gastrointestinal tract is changed by operations like subtotal gastrectomy, resection of intestine, or shunting of the intestine like enteroenterostomies, gastroenterostomies, pyloroplasty, etc., often the amount of fat in the stools is increased. In one study it was found that the average loss of ingested fat via the feces in normal animals was 2.7 per cent; in animals with gastroduodenostomy, 3.7 per cent; with gastrojejunostomy, 5.2 per cent. In gastroenterostomies there can be great variation in absorption of fat, depending apparently on how fast the food is transported from the stomach into the intestine.

In a few cases we have observed that a gastroenterostomy contracted and opened rhythmically, similar to a functioning pyloric sphincter. It seems to be important that food is not dumped from the stomach into the intestine rapidly, but that it leaves the stomach in small portions in rhythmic spurts. By this mechanism the intestine is not overloaded or irritated. Otherwise, food passes through the intestinal tract more rapidly than normally, and digestion and absorption suffer.

Changes in Digestion and Absorption with Old Age

We have had the chance of studying a number of elderly persons to observe changes in the gastrointestinal tract accompanying old age.

One significant finding has been that secretion of ptyalin drops markedly after age 60. The total volume of saliva falls also to only 10 or 20 per cent of the volume produced by young persons.

Digestion of starch by salivary ptyalin is important, because in the stomach the bolus of the ingested food is penetrated slowly by the hydrochloric acid and therefore hydrolysis of starch continues for quite a while within the stomach. Hawk and Bergheim, at your school, have demonstrated that approximately 80 per cent of the starch of potatoes and white bread can be digested in this way. In the aged, the deficiency in salivary secretion and frequent fibrotic changes in the pancreas seem to impair starch digestion. This may explain frequent complaints of gas and postprandial distention in older persons. We have treated this condition successfully in a number of persons with the use of various diastase preparations.

Like ptyalin, the secretion of gastric acid and pepsin falls in old age. To a lesser, but still significant degree, there is a drop in production of pancreatic lipase, and serum lipase falls about 20 per cent. The role of serum lipase is not entirely clear, but it may have something to do with fat metabolism. The secretion of trypsin likewise falls.

Not only secretion but also absorption diminishes in old age. We have demonstrated this with studies on galactose absorption, and others have found the same with vitamins.

Absorption of "Toxins" from the Gastro-Intestinal Tract

The aged theory of "auto-intoxication," on the basis of which the colon was resected for arthritis and other diseases, has passed into oblivion. More recently, however, there has been a reawakening of interest in the possibility of absorption of toxins, particularly bacterial toxins. This is demonstrated in the successful treatment of acute hepatic necrosis in animals with antibiotics. It has been observed that the left hepatic lobe, which is believed to receive most of its blood from the intestinal canal, is often more severely affected in cases of liver disease. Possibly hepatic coma is due in part to absorption of ammonia and other toxic metabolic products from the gastrointestinal tract. The

ammonia concentration in the blood, and particularly in the brain, seems to bear some relationship to the coma.

In gastrointestinal polyposis, phenols and phenylalanine, precursors of melanin, are probably absorbed. This may explain the fact that such patients sometimes exhibit patches of melanin pigment in the skin, particularly of the lips and periorbally.

Miscellaneous Observations

(1) *Competition in Intestinal Absorption*: With the ordinary glucose tolerance test, the blood sugar rises rapidly and returns to the fasting level within approximately an hour. In a number of persons, blood sugar may drop below the fasting levels and true hypoglycemia may manifest itself. When the same amount of sugar is given with fat or protein, the sugar curve in the blood is depressed and apparently no reactive hypoglycemia ever develops. We have no explanation at the present time why proteins, amino acids, or fats depress the absorption of simple sugar.

(2) *Intestinal Tone and Intestinal Absorption*: Normal tone and motility of the intestine are necessary for optimal absorption. When intestinal tone is diminished, absorption is depressed. This latter observation has been made for instance in the sprue syndrome. Administration of drugs that increase intestinal tone like prostigmine have been shown to improve absorption in conditions of intestinal atony. These observations lead one to wonder about the wisdom of the powerful anti-cholinergic drugs used in the treatment of peptic ulcer, which lower intestinal tone considerably.

(3) *Countercurrents in the Gastrointestinal Tract*: Physicists tell us that in any tube through which fluid flows, there is a small countercurrent along the wall of the tube, so that some particles are always traveling in a reverse direction to the main stream. This may explain a rather surprising observation: burlap seeds placed in the rectum may be recovered from the mouth or nose within 24 hours. Also, amebic cysts are found in the mouth of some persons. It is disputed whether these cysts are pathogenic. Whether they are pathogenic or not, an important and not yet answered question is, whether these cysts have come up all the way from the large intestine. The esthetic and hygienic implications of this phenomenon may be considered.

Discussion

Question: How may one obtain human pancreatic juice for use in experiments on digestion?

Answer: We pass a tube into the second portion of the duodenum for aspiration of the juice. We stimulate secretion by the use of dilute HCl, oleic acid, sodium oleate, or secretin.

Question: If the Thiry loop of which you spoke contains no bile or pancreatic juice, how can fat possibly be absorbed?

Answer: We feel that it is absorbed as chylomicrons after emulsification by intestinal bicarbonate and lipase.

Trichomonas Vaginitis
— Diagnosis and Treatment with Milibis

Walter J. Reich, M.D., Mitchell J. Nechtow, M.D., M. William Rubenstein, M.D., A. M. Doswald, M.D., Chicago

IN our experience at the Cook County Hospital gynecological clinic and private practice, trichomonas vaginalis vaginitis continues to be a problem to the gynecologist as well as to the general practitioner.[1] The condition occurs in about 15-20% of all women. Its treatment and prognosis still remain perplexing. The oft-repeated remark stating that no completely satisfactory specific medication has been found has led to the experimentation of many and various products in order to effect "a cure".

Briefly, from a clinical point of view, there are several important features to consider. (1) The patient must be evaluated as a whole. Though trite, this thought is important only as it focuses attention on the general health of the individual. Often we have noted that recalcitrant trichomonas infestation would disappear with striking regularity when an attendant secondary anemia, malnutrition, or anxiety states, etc. were treated successfully. External and internal hemorrhoids, especially with bleeding, were present in many such patients. (2) That when the general health and local pathology, especially that of the rectum, were corrected, the "cure" results were striking. Local medication would become surprisingly effective subsequent to rectal surgery. (3) The sources of reinfection must be given due detection. The husband's prepuce, bladder, and prostate can be troublesome sources of reinfection. Certainly the patient's own genitourinary tract can harbor the organism. (4) The healthy and adequately cornified structure of a normal vaginal mucosa must be maintained and seems necessary for adequate resistance and healing. A great many of the trichomonas vaginitis cases on vaginal cytological studies showed a "decrease" in cornification glycogen percentage. It follows, therewith, that a lowered glycogen content cannot yield enough lactic acid with a desirable acid pH of 4 to 5 in spite of the Doderlein's bacillus activity. The better the nutritional, vitamin, and blood values of the patient, the more likely that a "resistant" local vaginal wall will result.

In spite of the above mentioned principles, as well as additional advice regarding toilet habits, general hygiene and reinfection sources, there has been a need for a drug or drugs that would be effective, reliable and non-toxic. To that end Milibis®, brand of glycobiarsol,** a bismuth derivative of P-N-glycolylarsanilac acid was used. Each suppository contains 0.25 Gm. Milibis in a gelatin-glycerine base. It has a molecular weight of 499.07, and contains approximately 15% arsenic and 42% bismuth. This same preparation has been employed orally to combat amebic colon infestations.[2]

We suggest that office treatment should be initiated during the first visit and continued at three day intervals for two weeks. It consists of a thorough "shampooing" of the vulva, perineum, clitoris and vagina with pHisoHex®*** which is a non-irritating detergent containing the powerful bactericide 3% hexachlorophene.

The latter is used in the amounts of 2 to 5 cc. on a thoroughly wet cotton sponge. The lather produced is then wiped away with cotton. After a few minutes Milibis® powder is then insufflated into the vagina via an open speculum, in a dosage of about 2 grams. The patient is instructed to use a vinegar douche in about 16-24 hours. The suppositories were then inserted (one) into the vagina by the patient every night for 5 nights, followed by a weak vinegar douche, consisting of 1 tablespoon of white vinegar in 1 quart of water, the following evening. The patients were checked at three weekly intervals when hanging drops were examined. A negative case would be

Cook County Hospital Gynecologic Clinic, Chicago Medical School, Cook County Postgraduate School, and Grant Hospital, Chicago, Illinois

**Milibis, Winthrop-Stearns Inc.
***pHisoHex, Winthrop-Stearns Inc.

Table 1
In Vitro Trichomonacidal Activity of Milibis[3]

Milibis conc. in Johnson medium	Incub. period	Number of T. vaginalis in inoculum	Qualitative findings	Remarks
1:1000	48 hr.	0.5 million	All killed	Trichomonacidal
1:10,000	48 hr.	0.5 million	1 +	Supressive
1:100,000	48 hr.	0.5 million	4 +	Ineffective
Control	48 hr.	0.5 million	4 +	

checked again after her menstrual period During the menses gentle plain water cleansing douches were advised 2 to 3 times daily during the interval between the vinegar douche and the nightly insertion of the suppository in order to free vagina of blood as much as possible.

In vitro, Milibis® activity against trichomonas vaginalis was effective as shown in Table 1.

The patients were from the Cook County Hospital Out Patient Gynecology Clinic. There were 158 patients (151 negroes) with findings of trichomonas vaginitis. By clinical definition these were patients who complained of from a simple discharge to an acute vaginitis and in whom a positive hanging drop for trichomonas was obtained. The census of the clinic shows attendance of negroes to be 96% of the total patients. The age varied from 18 to 51 years with 91 multiparas and 67 nulliparas. In order of frequency the following symptoms were revealed: leucorrhea (discharge), burning, itching, soreness, intertrigo, urinary frequency and dyparunia. The duration of symptoms varied from 2 days to 7 years.

On the basis of three weekly negative hanging drops followed by a negative hanging drop after the menstrual period 126 patients were "cured" (81%) and there were 32 failures (19%). The duration of treatment varied from 4 to 12 weeks. There were no instances of local or systemic reaction.

CONCLUSIONS

1) Milibis® suppositories applied locally to the vagina can be used safely in the treatment of trichomonas vaginitis.
2) Of 158 patients 81% were "cured", and 19% failed.
3) There were no local or systemic side-effects noted.

SUMMARY

The treatment of trichomonas vaginitis with Milibis "a product containing both bismuth and arsenic" was studied in 158 patients. One suppository was used and inserted daily for 5 days vaginally, and a weak vinegar douche taken in about 12 to 16 hours. A negative hanging drop repeated after the next menstrual period gave a "cure" rate of 81%, with 19% failures or reoccurences. The patients were almost all negroes in an out-patient gynecology clinic. There were no local or systemic side-effects noted.

REFERENCES

1. Reich, Walter J., M.D., Rubenstein, M. Wm., M.D. and Reich, Jerome, M.D.: Diagnosis and Management of Common Gynecological Problems, Maryland Med. J. 2:241, May 1953.
2. Berberian, D. A., M.D., Dennis, E. W., Ph.D. and Pipkin, C. A.: The Effectiveness of Bismuthoxy p-N—Glycolylarsanilate (Milibis®) in the Treatment of Intestinal Amebiasis, Am. J. Trop. Med., 30:5, Sept. 1950.
3. Berberian, D. A., M.D. and Dennis, E. W., Ph. D.: The Trichomonacidal Activity of Milibis—in press.

COOK COUNTY HOSPITAL CASE RECORDS



Pericardial Tamponade Due to Tuberculous Pericarditis

JOHN C. KULIS, M.D., AND WILLIAM SAPHIR, M.D., CHICAGO

ACCUMULATION of fluid within the pericardial sac seriously interferes with the heart's pumping action and results in pericardial tamponade. The essential mechanical difficulty is an interference with diastolic filling. Paradoxic pulse, a reduction in cardiac output during inspiration, and increased venous pressure are the chief signs.

Because of many misconceptions about the disease, about two-thirds of cases are initially misdiagnosed[1]. Failure to recognize an underlying treatable disease may lead to progression and death.

The case to be presented here demonstrates the necessity to initiate treatment at an early date and before irreversible progressive changes have occurred. This is particularly true of tuberculous pericarditis where the demonstration of tubercle bacilli may be delayed for many days or weeks.

A seventeen year old negro male was admitted to the medical ward of Cook County Hospital December 31, 1954. He presented a history of a "chest cold" of two weeks duration, vague chest pains, productive cough with occasional hemorrhagic sputum, and epigastric distress and fullness of the abdomen. He had never been sick before except for occasional colds. One brother was said to have suffered from tuberculosis.

Physical examination revealed the patient to be acutely ill. There was marked dyspnea and moderate cyanosis. The temperature was 100.4 degrees F., the pulse rate 110 and regular, the respiratory rate 26, the blood pressure 130 mm Hg systolic and 78 mm diastolic. The neck veins were distended. There was flatness, decrease in breath sounds, and vocal and tactile fremitus over the right posterior chest below the scapular angle. The heart was apparently enlarged. The apex beat was felt just left to the midclavicular line in the 5th intercostal space. The left border of the cardiac dullness extended past the left anterior axillary line. The heart tones were muffled and distant. A loud, rumbling to-and-fro friction rub was heard over the entire precardium. The abdomen was distended and soft. The liver was enlarged to three fingers below the costal margin, and rather firm and tender. The remainder of the examination was not remarkable.

The laboratory findings were as follows: the urine contained one plus albumen, sugar was absent, the sediment was negative, the specific gravity was 1018. The blood count disclosed a hemoglobin of 53 per cent, a red blood cell count of 3,690.000, a white blood cell count of 5.750 with a differential count of 52 per cent polynu-

From the Medical Department, Cook County Hospital, Chicago, Ill.

clear, 26 per cent band cells, lymphocytes 20 per cent and monocytes 2 per cent. The sedimentation rate was 18 mm in one hour. The Kahn test was negative. The plasma proteins were 6.4 gm per cent with 3.5 gm per cent albumen and 2.9 gm per cent globulin. The serum cholesterol was 102 mgm per cent, the alkaline phosphatase 2.8 units, the icterus index 7, the cephalin flocculation 2, thymol turbidity 6, gamma globulin 1.10. The electrocardiogram showed sinus rhythm with low voltage, flat T waves in leads 2, 3, and AVL, inverted T waves in V2-V4.

COURSE

A tentative diagnoses of acute pericarditis and right pleural effusion was made. Treatment consisted in aspiration of about 500 cc of clear, straw-colored fluid from the right pleural cavity, penicillin 600.000 units intramuscularly twice daily, and intravenous infusion of 1000 cc of 5 per cent glucose in water. No favorable response was noted. On the third hospital day the patient's temperature was 101.8 degrees F. There was acute respiratory distress and moist chest rales were present over the bases bilaterally. The heart sound appeared weaker and more distant. A paradoxical pulse was noted. The abdomen became more distended and the liver had increased in size to four fingers below the costal margin. X-ray chest fluoroscopy revealed a large cardiac silhouette with globular configuration, poor pulsation and a density in the right lower lung field. Meanwhile, a blood culture was reported sterile, a blood preparation for L.E. cells was negative, and several sputa specimens were negative for acid fast bacteria on smear while the results for cultures were awaited. The Mantoux skin test was strongly positive.

Because tuberculous pericarditis remained a definite possibility and could not be excluded from our diagnostic considerations at this point, antimicrobial therapy was decided upon. Streptomycin 1 gm daily, together with isonacid 100 mgm t.i.d. and para-aminosalicylic acid 4 gms t.i.d. was started on the fourth hospital day.

Over the next few days the condition became steadily worse. Respiratory distress, orthopnea, and distention of neck veins increased. The pulse became weak and thready, the blood pressure fell to 90 systolic over 70 diastolic. A pericardial paracentesis was done in the left fifth intercostal space just inside the midclavicular line. Approximately 500 cc of grossly bloody fluid was removed. The response was gratifying. The blood pressure rose to 120 systolic over 90 diastolic, the dyspnea subsided. Two days later, an additional amount of 500 cc dark, sanguinous fluid was removed from the pericardial cavity. Thereafter, the improvement was slow and was interrupted by bouts of fever to 103 degrees F., occasional attacks of dyspnea and precordial distress. The pericardial friction rub gradually subsided and the heart sounds became stronger and more audible. The area of cardiac dullness diminished in size and the apex beat became palpable in the left midclavicular line. On the 10th of February the patient was afebrile and asymptomatic. The sedimentation rate was 14 mm in one hour. On the 17th of February the report of a positive sputum culture for tubercle bacilli was received. The patient was transferred to the tuberculosis section of the hospital.

COMMENT

The presence of an acute cardiac tamponade demands immediate action regardless of the etiology. The life saving procedure of pericardial needle aspirations was clearly apparent in our case. Definitive treatment of the accompanying pericardial disease, however, depends entirely on etiologic considerations. Amongst these are encountered tuberculosis, uremia, lupus erythematosus, Hodgkin's disease, viral diseases, tumors of the heart, leukemia and hemorrhagic diseases. It is clear that the determination of these various etiologic factors not only demands the facilities of excellent laboratories but also considerable amount of time. This is particularly true of tuberculosis, one of the more common causes of hemorrhagic pericarditis.

As shown by the classical studies of Osler, Riesman, and others[2,3,4] tuberculosis pericarditis usually arises by extension from a neighboring tuberculosis focus, most commonly the hilar lymph nodes. Another mode of spread is hematogenous implantation of the pericardium in miliary tuberculosis. Both forms of dissemination appear serious enough to suggest antimicrobial therapy at the earliest possible moment. It is unfortunate that the demonstration of tuberculosis by a positive bacterial culture or guinea pig tests may take from three weeks to three months. It is our belief that specific treatment should be instituted immediately if the family

history, the past history, the x-ray findings, and perhaps suggestive physical findings, such as in our case, raise a fair degree of suspicion for tuberculosis pericarditis. The excellent results obtained in our case in the face of a grave clinical picture encourage us to recommend such a procedure in similar cases where the time factor in initiation of treatment appears of paramount importance.

SUMMARY AND CONCLUSIONS

A case of acute hemorrhaggic pericarditis with cardiac tamponade is presented. Because of suggestive evidence of tuberculous etiology immediate specific antimicrobial therapy was instituted. Rapid recovery was established by the time a positive culture for tubercle bacilli was reported. It is suggested that such a course of action be followed in view of the obvious importance of early initiation of treatment.

104 S. Michigan Ave.

William Saphir, M.D.

REFERENCES

1. Williams, Conger, and Soutter, Lamar. Arch. Int. Med. **94**: 571, 1954.
2. Osler, W. Am. J. M. Sc. **105**: 20, 1893.
3. Riesman, D. Am. J. M. Sc. **122**: 6, 1901.
4. Metcalf, C. R. Boston Med. & Surg. J. **160**: 404, 1909. Keefer, C. S. Ann. Int. Med. **10**: 1085, 1937.

‹ ‹ ‹ › › ›

Funnel chest

Unless pectus excavatum is corrected at an early age, preferably before the age of 6 months, it leads to a more complicated type of deformity characterized by a depression of the sternum as well as a defect of the lower portion of the thoracic cage. From both a physiologic and psychologic standpoint, early treatment is important. Correction is achieved by surgical intervention. A series of seven cases is presented. *Haven M. Perkins, M. D. Pectus Excavatum: Its Surgical Treatment. West Virginia M. J. August* 1955.

‹ ›

Pyogenic infections

Erythromycin and oxytetracycline are effective antibiotics for local therapy of pyogenic infections of the skin. No example of sensitization of the patient to the antibiotics used was encountered. The combination of erythromycin-neomycin in an ointment base gave no decided advantage over the antibiotics singly in this type of infection. The same routine of treatment with omission of an antibiotic gave decidedly poorer results than those when antibiotics were used. *J. Lowry Miller, M. D., et al. Topical Therapy with Antibiotics. New York J. Med. August 1, 1955.*

Twenty thyroidectomies a day

My father performed more than 17,000 operations for goiter during his active surgical years. Think of what has happened as a result of the use of iodine and now, radioactive iodine in this field of human disease. The then common exophthalmic goiter is a rarity today, as is toxic goiter. The time when a single surgeon performed 20 or more such operations in one operative session has gone, never to return. *Charles W. Mayo, M.D. The Role of Medicine and Doctors in International Relations. J.M.A. Alabama, June* 1955.

‹ ›

Fresh frozen plasma

The Hemophilia Foundation, Inc., has successfully established a program to maintain a stock of type-specific fresh frozen plasma for the hemophiliacs in the New York area. This fresh frozen plasma is so simple to use that the attending physician may accept a patient in the knowledge that he may be able to relieve suffering in the home. Thus, for the more common episodes of hemorrhage many days of hospitalization may be avoided. *Richard E. Rosenfield, M.D. Treatment of Hemophilia. New York J. Med. April 15, 1955.*

CASE REPORTS



Chronic Gastro-Intestinal Hemorrhage Diagnostic Enigma

Charles W. Pfister, M.D.*, and B. J. Tatarowicz, M.D., F.A.C.S., Chicago**

CHRONIC intermittent blood loss from the gastro-intestinal tract leading to anemia, weight loss, and chronic debility, can present a diagnostic challenge to the most experienced; first, in establishing the diagnosis of blood loss, and secondly, in localizing the responsible lesion. In approximately 15% of the cases of gastro-intestinal bleeding, the exact site is not determinable[1,2] and in a much larger percentage, the site of bleeding remains questionable despite complete diagnostic study.[3,4,5]

The following case is reported because of its intense interest as a medical diagnostic problem; because of the vague and confusing initial complaint on the part of the patient, and because of the discovery of two bleeding sites by the surgeon at the time of the operation for a correctly predetermined single lesion.

A 64 year old white female, case No. 6959, was admitted to the Resurrection Hospital on November 28, 1954, because of progressive weakness of the legs, with peculiar sensations of paresthesia for about 4 months. In recent weeks there had been some anorexia and a gradual progression of her chronic constipation. Her past personal history was non-contributory. Her family history was that of arteriosclerosis.

Physical examination revealed a very definite pallor but no loss of tissue turgor. A soft systolic murmur was heard over the aortic area of the heart; the lungs were resonant throughout. The abdomen revealed no masses, and the liver, kidney, and spleen were not palpated. Rectal examination revealed only minimal hemorrhoids. Examination of the lower extremities revealed the presence of superficial varicosities. Neurologic examination showed patchy loss of vibration sense. She was studied as a possible case of pernicious anemia with early, combined degeneration of the spinal cord, and treated with Vitamin B_{12}. During hospitalization she improved somewhat. Laboratory findings revealed a Papanicolau Class I, cervical smear; electrocardiogram was normal; x-ray of the chest was normal; x-ray of the dorsal spine revealed osteoarthritis with some osteoporosis. Barium meal revealed no abnormalities of the esophagus, stomach, or duo-

**Associate Stritch School of Medicine, Consulting Senior Active Staff, Resurrection Hospital, Chicago, Illinois*

***Consultant-Senior Active Staff, Resurrection Hospital, Active Attending Staff, St. Mary of Nazareth Hospital, Chicago, Illinois*

denum; colon revealed a filling defect in the cecum. Intravenous urogram disclosed a double pelvis and ureter on the left side. Re-examination of the colon within 5 days verified the presence of a filling defect at the tip of the cecum in the region of the ileocecal valve, highly suggestive of a polypoid carcinoma.

Admission blood count was 2,470,000; hemoglobin, 7.3 gms.; 5,100 wbc; 60 segs; 2 stabs; 20 lumphs; 1 monos; 6 eosins; 1 basos. Sedimentation rate was 39 mm; hematocrit was 35%. Urinalysis-specific gravity, 1.025; negative for albumin and sugar. Original reticulocyte count was .5%. This rose only to 2.6% after administration of vitamin B_{12}. Blood calcium, 1.5%; phosphorous, 35; gastric analysis, fasting volume was 30 cc. with negative free hydrochloric acid, and 4 degrees of combined. After histamine, the volume rose to 45 cc., free hydrochloric acid, 25 degrees, and combined to 4 degrees. Stool examinatin was positive for occult blood. Vibration sense in the legs improved to normal on vitamin B_{12}, however, and the patient left the hospital on 12/9/54, greatly improved. Her final blood count was 3,300,000, with 7.73 gms. hemoglobin; the sedimentation rate was 15 mm; the cells described revealed slight hypochromia, and moderate anisocytosis and poikilocytosis.

She was followed carefully as an out-patient but weakness became so severe that she was readmitted to the hospital on 12/27/54, with a diagnosis of chronic gastro-intestinal hemorrhage, cause undetermined. Urinalysis was again within normal limits; the blood count had dropped to 2,600,000, with 6.2 gms. hemoglobin; 7,700 wbc; 80 segs; 19 stabs; 16 lymphs; 2 monos; 1 eosins; the sedimentation rate was 32 mm; hematocrit was 25; there was moderate anisocytosis. Repeated stool studies revealed the presence of occult blood. Stool studies for cysts and amoeba were negative. She was given multiple blood transfusions and prepared for surgery with a preoperative diagnosis of carcinoma of the cecum. Before celiotomy the hematocrit was 43%; hemoglobin, 83%.

On initial exploration of the abdomen a 4½ x 4½ cm. polypoid lesion was found along the postero-lateral cecal wall. Subsequent micropathology disclosed this to be an infiltrating, poorly differentiated mucus-secreting (Grade III) adenocarcinoma. A right hemicolectomy was effected with an end to end anastomosis between the ileum and the remaining transverse colon. Prior to closure, final re-exploration revealed a tangerine-sized neoplasm on the antemesenteric border of the distal jejunum. Inasmuch as the lesion appeared benign, it was excised much as a Meckel's diverticulum would be removed, and the bowel was then closed transversely. On gross examination this lesion apparently had been responsible for the patient's marked melena, rather than the Cecal Carcinoma for which the patient was operated. Microsections disclosed a leiomyoma arising from the musculature of small intestine. The patient enjoyed a smooth convalescence and was discharged on 1/12/55, the 9th postoperative day, with a hematocrit of 53%, and a hemoglobin of 14.8 gms.

COMMENT

Chronic blood loss from the gastro-intestinal tract can lead to a confusing clinical picture which at times simulates that of pernicious anemia. Pin-pointing the site for chronic intermittent blood loss is difficult and presents a diagnostic challenge that often terminates in exploratory laparotomy.[6] In the present case, although repeat x-ray studies correctly indicated a lesion in the cecum which is commonly associated with anemia, nevertheless an unsuspected second jejunal lesion was the probable cause of the patient's severe blood loss.

Marshall,[7] in a recent discussion of smooth muscle tumors of the alimentary canal, points out the fact that because of their relative infrequency, leiomyomata may not be suspected or found until they reach a sufficient size to obstruct the alimentary system, or until ulceration of the overlying mucosa causes serious or even fatal hemorrhage.

Although malignant disease of the small intestine is not too common, one shall bear in mind that leiomyomatous tumors may undergo malignant degeneration and form sarcomatous lesions which often can only be detected by meticulous microscopic study. Kustrup[8] reports a Leiomyosarcoma of the jejunum in a patient whose clinical picture parallels previous reports, wherein the preoperative diagnosis was duodenal ulcer due to the symptomatology and irregularities in the roentgenologic pattern of the duodenum. It is generally agreed that the presence

of an ulcerated tumor in the small intestine must cause a reflex pyloroduodenal spasm to account for the almost uniform symptomatology of this interesting group of patients.

SUMMARY

A case is reported showing a Leiomyoma of the small bowel as the cause of severe chronic blood loss, simulating Pernicious Anemia, in association with a correctly diagnosed carcinoma of the cecum. It is our endeavor to emphasize the importance of a very careful exploration despite the discovery of a suspected lesion, and secondly, to point out the symptomatology of small bowel tumors so that these may at least be kept in mind.

REFERENCES

1. Harrison, T. R.; Principles of Internal Medicine First Ed. The Blakiston Co., New York, 1950 p. 200
2. Atik, M., Simeone, F. A.; Massive Gastro-Intestinal Bleeding Arch. Surg., **69**:355; Sept. 1954
3. Loe, R. H.; Massive Hemorrhage in the Upper Part of the Gastro-Intestinal Tract
   Arch. Surg.; **61**:183; July 1950
4. Leas, R., Hauser, H.; Differential Diagnosis of Hemorrhage From the Gastro-Intestinal Tract
   Neb. Med. J.; **35**:68-73 March 1950
5. Bockus, H. L., Ferguson, L. K., Thompson, C., Roth, J. L. A.; A. M. A. Jour.; **152**:1228-1230 July 1953
6. Whittaker, L. D.; Obscure Gastro-Intestinal Hemorrhage Ill. Med. J. **106**:185-189 Sept. 1954
7. Marshall, S. F., Cherry, J. W.; Smooth Muscle Tumors of the Alimentary Canal
   Surg. Clin. North Amer. **35**:719-733 June 1955
8. Kustrup, J. F., Mulla, N., Robinson, J. A.; Leiomyosarcoma of the Jejunum
   J. I. C. S. **23**:476-480 April 1955

‹‹‹ ›››

The tranquilizer

In a series of 64 disturbed mental defectives and deteriorated schizophrenic women, Serpasil® was found to be an effective drug. This drug offered the advantage of the absence of the hypnotic and hangover effect commonly associated with barbituates and chloral hydrate. Although bradycardia occurred in a small percentage of patients with maintenance doses of 1-2 mgm. daily, it was readily correctable with modification of dosage and the occasional use of atropine gr. 1/100. This finding would suggest that Serpasil in the dosage used in this study has a fairly wide margin of safety. *Joseph Shapiro, M.D. Serpasil — Its use as a Sedative in Certain Disturbed Mental Patients. J. Oklahoma M.A. June* 1955.

Hard to do

So long as fruits are fermented and alcohol distilled for man's consumption, the problem of alcoholism and drunkenness will complicate existence. It will not be solved by prohibition or police action or an excess of piety, but it will gradually be modified and will certainly be most intelligently approached by applying the methods of research, of discussion, and of education. Temperance in the use of alcohol will not be achieved by an intemperate attitude on the part of those who seek to abolish its evils; much may be accomplished by accepting and promulgating the counsel of Paul to the Philippians: "Let your moderation be known to all men." *Editorial. Conference on Alcoholism. New England J. Med. Jan. 13, 1955.*

Situs Inversus Viscerum

Glenn E. Wright, M.D., Woodstock

SITUS inversus viscerum, or displacement of viscera abnormally to the opposite side of the body, has been known since 1610 A. D., but definite information was lacking up to the time it was first demonstrated by x-ray in 1897.

In the period 1910 to 1947 there were 76 cases discovered in 1,551,000 registrations at the Mayo Clinic. Situs inversus varies greatly in the number of organs involved and to their degrees of involvement.

In a complete transposition the heart lies to the right of the midline and its chambers are reversed, the apex being the right ventricle which arises from the aorta. The aorta arches to the right, giving off the innominate artery.

The lungs are in structure reversed, the right being bi-lobed and the left being tri-lobed.

Intra-abdominally, the spleen is on the right and the gall bladder on the left.

The entire intestinal tract is reversed, with the cecum and appendix on the left side and the sigmoid flexure of the colon in the right iliac fossa.

However, strange as it may seem, the pain of appendicitis in a person with transposition of the viscera is frequently on the right side and the pain of a diseased gall bladder is usually on the left.

Diagnosis of situs inversus can be suspected if, on physical examination, the apex beat is found to the right of the right mid-clavicular line — dullness of the liver on the left and stomach tympany on the right. This may, of course, be confirmed by chest x-ray and G. I. series. While situs inversus may be considered an anatomic curiosity, its early recognition could be important in some surgical emergencies.

Situs inversus per se is not incompatible with normal health and living.

The nature and origin of situs inversus has led to many theories, none of which appear to be wholly factual.

A 72 year old female, living and well, mother of 10 children, grandmother of 28 grandchildren; had scarlet fever in 1920; had a hysterectomy and bilateral salpingectomy and oophorectomy in 1927; had gall bladder surgery in 1932, after being severely jaundiced and bedridden for four months, with a right side incision.

On January 14, 1953 the patient had a chest plate and G. I. series at the Woodstock hospital. Dr. Russell F. Wilson's report shows this patient to have an unusual anatomical curiosity.

His report: fluroscopic and radiographic examination of the chest and gastro intestinal tract shows the heart to be on the right under the fluroscope, as well as on the films. The stomach and colon are both rotated. The pyloric end of the stomach is to the left. The liver is under the left diaphragm. Both the stomach and duodenal bulb are well filled. There is no evidence of a lesion. The colon also fills well with the opaque enema and seems to be perfectly normal. The heart is normal in size. There is no pathology in the lungs.

Diagnosis: There is a transformation of all of the thoracic and abdominal organs, all shifted just opposite the normal anatomy.

PATHOLOGY CONFERENCES

Edwin F. Hirsch, Department Editor



1. Embolic infarcts of the brain and other viscera with chronic rheumatic endocarditis

2. Acute thrombo-ulcerative endocarditis of the mitral valve

Edwin F. Hirsch, M.D., Chicago

Case 1. Embolic infarcts of the brain and other viscera with chronic rheumatic endocarditis.

This white female aged 55 entered St. Luke's Hospital in the care of Doctor Fred Ball on August 3, 1953 and died on August 10. She was found unconscious on the street and brought to the hospital by the police. Her pulse was 88 and her respirations were 26 per minute. Neurological examination demonstrated paralysis of the right upper extremity, bilateral positive Babinski, right lower facial paralysis, right deviation of the tongue, left deviation of the head, ptosis of the eyelid, and temporal deviation of the left eye.

The blood had 4,600,000 red blood cells and 11,600 leukocytes per cubic mm. and 12.6 gm. per cent of hemoglobin. The urine had 30 mgm. percent albumin but no sugar. The nonprotein nitrogen of the blood was 41.5 mgm. and the sugar 114 mgm. per cent. The clear spinal fluid was under a pressure of 160 mm. of water. The protein and Wassermann tests were negative. A note in the clinical record on August 5 recorded that the patient has old rheumatic heart disease with aortic and mitral stenosis and auricular fibrillation. The hemiplegia was thought to be embolic, although hemorrhage or thrombosis could not be excluded.

The temperature gradually rose to 104°F., the patient remained unconscious, respirations became labored and rapid, and finally death occurred.

The essential portions of the anatomic diagnosis of the complete necropsy are.

Recent embolic infarct of the upper portion of the pons;

Marked chronic calcified fibrous endocarditis of the mitral valve of the heart — mitral stenosis;

"Ball" thrombus of the left auricle of the heart;

Recent embolic thrombosis of the left renal artery;

Extensive recent hemorrhagic infarct of the left kidney;

Focal recent hemorrhagic infarct of the right kidney;

Chronic fibrous endocarditis of the tricuspid and of the aortic leaflets of the heart — tricuspid and aortic stenosis;

Hypertrophy of the myocardium and dilata-

From the Henry Baird Favill Laboratory of St. Luke's Hospital, Chicago.

tion of the chamber of the left ventricle of the heart;

Chronic passive hyperemia of the liver and spleen;

Hypostatic hyperemia and edema of the lungs; etc.

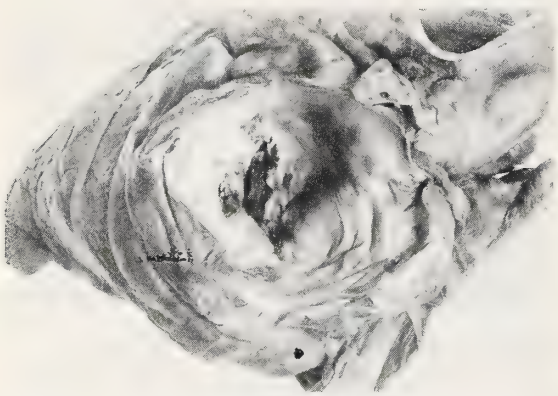


Figure 1. Photograph illustrating the chronic rheumatic endocarditis with marked stenosis of the mitral valve and the endocardial hemorrhages of the leaflets.

The body of this white woman weighed 140 pounds and was 163 cm. long. There was an old laparotomy scar in the right upper quadrant of the abdomen and opposite this were adhesions with the abdominal viscera. The gall bladder had been removed. Both lungs were expanded and had no significant adhesions with the chest. The aorta had thin fibrous and fatty plaques. A gray red blood clot filled the lumen of the left renal artery and extended in the vessel 2.3 cm.; the lumen of the right renal artery was patent. The lumen of the pulmonary veins was dilated and in the left auricle of the heart was a "ball" thrombus 5 by 3.5 by 2 cm. (Figure 3). The opening of the mitral valve was a curved slit 2 by 0.8 cm., the fibrous thickened leaflets standing out as a ledge, and each had an endocardial hemorrhage on the auricular surface (Figure 1). The chordae tendineae were shortened and thickened by fibrous tissues. The leaflets of the tricuspid valve were fused and thickened by fibrous tissues and their chordae tendineae thickened as well as shortened. The oval tricuspid opening was 2.5 by 2 cms., and the rigid leaflets stood out as a fibrous ledge 1.3 cms. wide. The leaflets of the aortic valve also had fibrous thickenings and a fusion of their commissures (Figure 2). The leaflets of the pulmonic valve were spared. Both lungs were edematous and hyperemic, the right weighing 400 gm. and the left, 350 gm. The myocardium was moderately hypertrophied. The heart weighed 500 grams.



Figure 2. Photograph illustrating the chronic rheumatic endocarditis of the aortic valve.

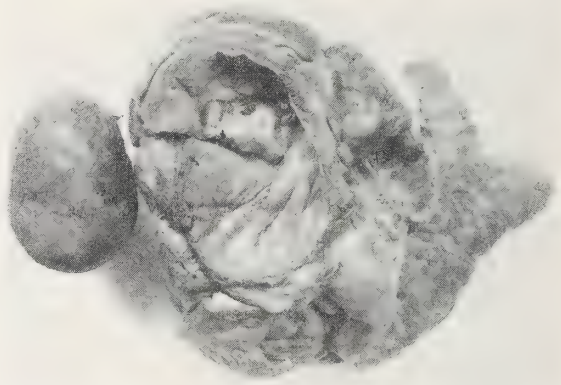


Figure 3. Photograph of another heart with chronic rheumatic mitral endocarditis in whose left auricle a "ball" thrombus had formed similar to the one observed in this patient.

The right kidney weighed 140 gm. and near the center of the convex edge was an infarct 3 by 2 cm. on the surface. The left kidney weighed 150 gm. and practically the entire kidney, especially the cortex was infarcted (Figure 4). The liver weighed 1250 gm., the hard elastic spleen 80 gm.

The brain with the upper half of the dura weighed 1450 gm. The upper portion of the pons to the cerebral peduncles was softened, a region 4 by 2 by 1 cm. Surfaces made by cutting were soft and without hemorrhages. The cerebral arteries had thin walls. The dural and cranial sinuses and the middle ears had no note-

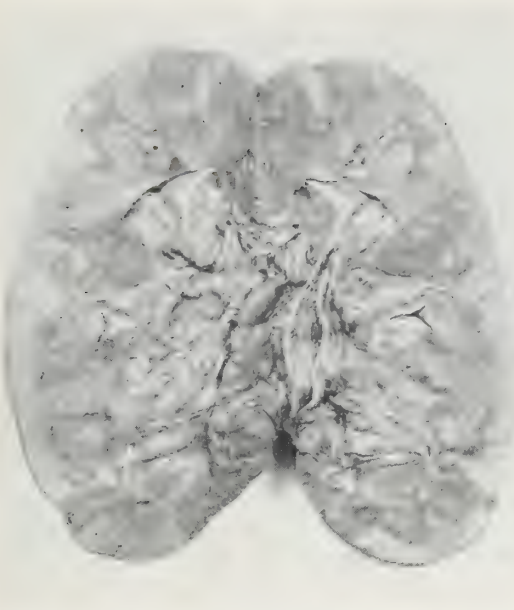


Figure 4. Photograph illustrating the extensive embolic infarction of the right kidney.

worthy changes. The structures of the neck had nothing remarkable. After fixation in a solution of formaldehyde the brain was sectioned and examined with more detail. The upper portion of the pons had the region of softening mentioned.

Comment

Chronic rheumatic heart disease in this patient was complicated by the formation of thrombi in the left auricle, more specifically on the auricular surface of the scarred leaflets of the mitral valve. A mass of thrombus material dislodged into the left auricle became a loose body on which further deposits of blood elements occurred. This produced the ball thrombus. Fragments swept off from this or from thrombi formed on the scarred mitral leaflets became emboli which lodged in the kidneys and pons to produce infarcts. The infarct of the pons, of course, affected a vital structure and eventually caused death. The heart, as disclosed by the necropsy was severely injured by the rheumatic disease, not only the mitral but also the tricuspid and aortic valves.

Case 2. Acute thrombo-ulcerative endocarditis of the mitral valve.

A married negress aged 29 years entered St. Luke's Hospital in the care of Doctors Robert A. Beebe and N. Flaherty on November 6, 1953 and died on December 4, 1953. According to the clinical record she had been in excellent health until about October 7, 1953 when she had diarrhea associated with yellow watery stools, but not accompanied by abdominal pain, nausea, or vomiting. This acute illness persisted for about a week, and with treatment by her physician subsided after another five or six days. Her last menstrual period began on October 3, 1953, the next was expected to begin on November 2, but on October 23, a severe metrorrhagia began that continued for nine days. She had been married for 10 years, but never pregnant, and pelvic infection was denied.

When admitted to the hospital she had moderate vaginal bleeding and generalized muscular weakness. Her temperature was 102.4°F., the pulse was 90, and the respirations were 16 per minute. The blood pressure was 110/70 mm. of mercury. The heart was not enlarged and had no murmurs. The abdomen and pelvis had no changes.

The blood on November 21 had 3,000,000 erythrocytes and 5,100 leukocytes per cubic mm. Several days later the sedimentation rate was 90 mm. in an hour. Four roentgen films of the chest, an intravenous pyelogram, and a sternal bone marrow examination disclosed nothing significant.

The temperature of the patient oscillated daily between 98 and 105°F., the pulse fluctuated correspondingly. Vaginal bleeding stopped without specific therapy; a tuberculin test and a heterophil agglutination test were negative. Repeated blood cultures were sterile, except one with a growth of staphylococcus aureus. Various antibiotics had no effect on the disease and with the fluctuating temperature the patient began to have definite chills. The patient gradually grew worse despite the use of therapeutic agents such as ACTH, primaquine, and died on December 4, 1953 without a satisfactory clinical diagnosis.

The significant items in the anatomic diagnosis of the complete necropsy are:

Acute thrombo-ulcerative endocarditis of the anterior leaflet of the mitral valve;

Staphylococcus aureus septicemia;

Multiple septic infarcts of the myocardium of the left ventricle of the heart;

Acute nephrosis and multiple focal abscesses of the kidneys;



Figure 5. Photograph illustrating the small subepicardial abscess (A) at the apex of the heart.

Marked hyperemia and multiple recent infarcts (abscesses) of the lungs;

Bilaterial acute serofibrinous pleuritis;

Slight ascites, hydrothorax and hydropericardium, etc.

The body of this negress weighed 130 pounds and was 158 cm. long. The abdomen contained about 200 cc. of a clear limpid yellow fluid. Each pleural space had about 150 cc. of a turbid yellow fluid with fibrin plaques and each lung had a few fibrous adhesions with the parietal pleura. The pleural surface of each hypostatically edematous and hyperemic lung was covered with a fibrinous exudate. The right lung weighed 700 gm., the left 570 gm. The right lung on surfaces made by cutting had scattered focal abscesses ranging to 1 cm. diam. The pericardial fluid was moderately increased. The epicardium was smooth except a hemorrhagic tissue 1.5 cm. in diam. in the anterior surface of the apex of the left ventricle (Figure 5). Beneath this was a small abscess that extended into the myocardium. The heart weighed 320 gm. The routine examination of the heart demonstrated on the auricular surface of the anterior mitral leaflet a granular friable gray tissue 1.2 by 1.2 cm. and 1 to 3 mm. thick (Figure 6). The myocardium of the lateral wall of the left ventricle and of the septum had scattered foci of gray 1 to 2 mm. in diam. The aortic, tricuspid, and pulmonic valves and other structures of the heart had no significant changes. The kidneys were large, each weighed 210 gm. Multiple yellow abscesses 1 to 2 mm. in diam. and surrounded by a halo of hemorrhagic tissue were scattered in the subcapsular surfaces (Figure 7) and deeper portions of each kidney (Figure 8). The changes of the kidneys otherwise were those of an acute nephrosis. The liver weighed 1,550 gm., but the usual lobule structure, focal fatty changes but no abscesses. The spleen weighed 230 gm. had hyperemic tissues and a focus of

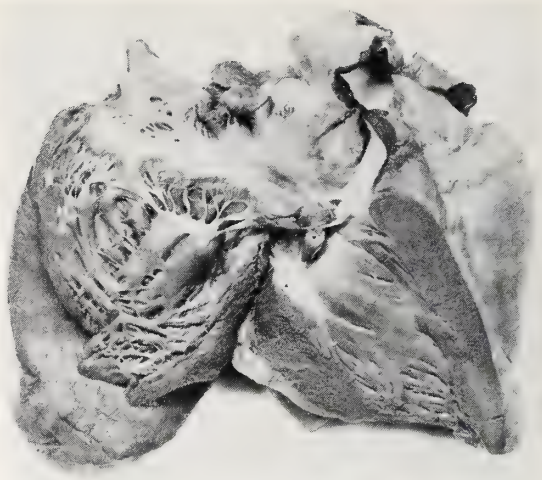


Figure 6. Photograph illustrating the thromboulcerative endocarditis of the anterior leaflet of the mitral valve.

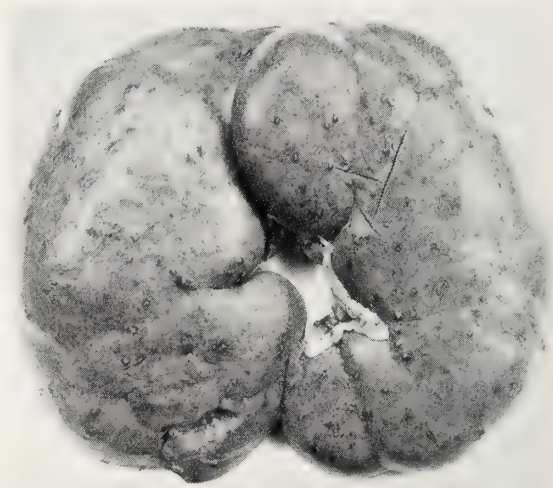


Figure 7. Photograph illustrating the subcapsular abscesses of the kidneys.

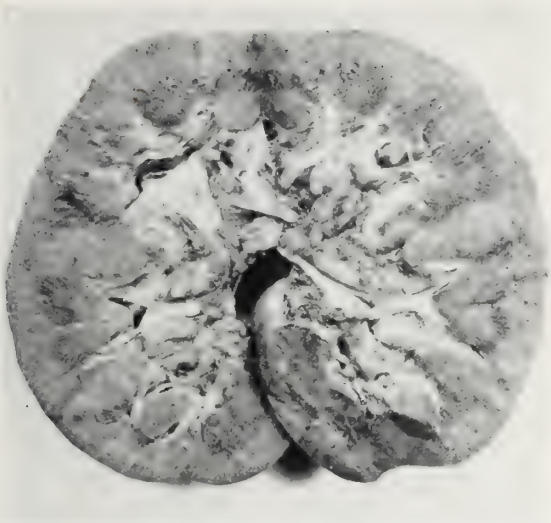


Figure 8. Photograph illustrating the multiple focal abscesses in the renal parenchyma.

necrosis 2 mm. in diam. The uterus and adnexa had no significant changes, except an old healed left fibrous salpingitis. Careful search in the tissues and blood vessels of the trunk, the neck, the brain, and the extremities failed to demonstrate a phlebitis or primary focus of infection. Cultures of the heart's blood, the left and right pleural fluids, the spinal fluid, the pericardial fluid, the exudates recovered from abscesses of the kidneys yielded a growth of staphylococcus aureus, in several with other contaminating organisms.

Histological preparations of the tissues with abscesses had foci of necrosis with dense exudates of polynuclear leukocytes and masses of cocci. Focal abscesses were demonstrated in the brain.

Comment

The original focus of infection from which the secondary thrombo-ulcerative endocarditis of the mitral valve developed is not clearly established by the clinical history or the necropsy. The illness during October seems to be related and probably is when the staphylococcus infection of the mitral valve occurred. The antibiotics—penicillin, streptomycin and terramycin—and other chemotherapeutic agents failed to stem the course of the infection. The illness of this patient presented a difficult clinical diagnostic problem. The necropsy later demonstrated the thrombo-ulcerative endocarditis of the mitral valve and the septicemia.

‹‹‹ ›››

Aortic reconstruction

It seems definitely established that aortic reconstructions may be fashioned with great reliability and with relatively little hazard using plastic prostheses, or human arteries preserved either by simple freezing or freeze-dry techniques. There is reason to believe that all three types of reconstructions will function well for several years at least — and several have continued to function without accident for over three years. For these reasons we feel there is sufficient evidence at hand to recommend aortic excision and reconstruction for those localized diseases which threaten life and/or impose severe disability. These conditions include abdominal aortic aneurysm, aortic thrombosis with ablation of femoral pulses, and probably long coarctions which cannot be corrected by excision and primary suture. *C. Philip Lape, M. D. Reconstructive Arterial Surgery — Progress Note. J. Maine M. A. June* 1955.

Cures for baldness

Two new treatments for common baldness have been introduced recently. One treatment—which was reported in a letter to the editors of the British Medical Journal and is now being exploited by an American hair-growing institute—consists of the use of roniacol, a derivative of niacin. It seems that the drug was administered to patients for the treatment of intermittent claudication and two of the patients "proudly and happily" volunteered the information that the tablets had grown a good crop of hair on their bald pates. Hair grew after taking 250 tablets and an incidental finding was the observation that scalp hairs appeared on heads that were previously barren. It would seem that with the amount of niacin consumed in this country, one would expect bald heads to be the unusual rather than the commonplace. The Glasgow physician who wrote the letter confessed that he had not personally had the time to take the tablets to cure his own advanced baldness. The other treatment is being exploited by a prominent drug house. The cover of the advertising brochure proclaims Premarin Lotion for the treatment of acne vulgaris, seborrhea, and premature alopecia. The text inside the cover states that one observer "studied 75 patients with various skin and nail disturbances which appeared to be related to a deficiency of estrogen." From this series, the case histories of six patients, three males and three females, were selected to illustrate scalp lesions responding to topical estrogen therapy: "Within three to six weeks alleviation of symptoms and reduced hair loss were noted." Nowhere in the advertisement does it state that Premarin Lotion grows hair and indeed a detail man from the company was quick to make that plain to me. But it does "control hair fall," they say. The implication is there. The tune is an old familiar one, the source a surprising one. *Herbert Rattner, M.D. What's New and What's True of What's New in Dermatology. California Med. July 1955.*

‹ ›

One who is too wise an observer of the business of others, like one who is too curious in observing the labor of bees, will often be stung for his curiosity.

— Pope

Early lung cancer

It appears more progress could be made if efforts were made by every physician to definitely diagnose every patient who has a cough no matter how slight, for this is the tip-off to the presence of the early squamous carcinoma, and it is in these that a great salvage can be anticipated. From previous experience, it seems that few centrally located squamous carcinomas will be detected in an entirely asymptomatic phase. In spite of the fact that the results of treatment in this particular group of cases is a little discouraging, there is no question but that early surgery in such silent cases is the procedure of choice. One should not watch such lesions for long periods of time, nor should one waste time with repeated bronchoscopies, bronchograms, repeated search for tubercle bacilli, and the like. One thoroughly accurate diagnostic study should suffice, and if no definitive diagnosis is made, then exploratory thoracotomy should be advised, if there is any question at all of the possibility of carcinoma being present. *Robert P. McBurney, M.D. Asymptomatic Bronchogenic Carcinoma. J. Tennessee M. A. August 1955.*

‹ ›

This is life

The person fears death most who fears life most, and the one who lives with the realization that he has but one life to enjoy is the person who, in his waning years, is as happily satisfied as ever. *John M. Dorsey, M.D., The Benefits of Senectitude. Geriatrics. March 1955.*

‹ ›

At the present time, tropical conditions are changing—somewhat in the way that communities in the United States and Great Britain were developing a century ago. People are leaving the country to live in large cities. They are starting heavy industries. Rural populations are getting mixed up with townsfolk, and primitive stocks of people are attempting, for the first time, arduous occupations such as coal mining. All these changes lead to the social conditions which specifically favor tuberculosis. . . . . We may expect an increase in tuberculosis in tropical areas during the next half century. Harley Williams, M.D., Nat. Tuberc. A. Tr., May, 1954.

EDITORIALS

Urogenital cancer in children

Cancer is the second most common cause of death in children under 15 years of age. Urogenital neoplasia ranks second only to leukemia in the incidence of pediatric malignancy.

Wilms' tumor is the most common malignancy of the kidney. It grows rapidly and may assume a large size before the child is brought to the physician.

Hematuria and pain are infrequent. Vague nausea and loss of appetite may be the only symptoms. Hypertension occurs in three-quarters of these children and blood and urine examinations usually are negative. Diagnosis is made with intravenous or retrograde pyelography.

The treatment of choice is immediate surgical removal of the kidney. Preoperative radiation therapy is advocated when the tumor has grown sufficiently to cross the midline to the opposite side. The overall cure rate is 40 per cent.

The common bladder tumors usually are sarcomatous in nature. They are easily overlooked unless urinary retention occurs. Hematuria and dysuria are symptoms of advanced tumors. Cystoscopy and biopsy afford the correct diagnosis. Extension and metastasis occur early. A few cures have been reported when the entire bladder is removed and the ureters transplanted to skin or bowel.

Tumors of the testis occur most frequently in infancy. The majority are embryonal carcinoma. Smooth enlargement of the affected testis without scrotal attachment is the common early manifestation. Early orchiectomy with postoperative irradiation of the abdominal lymph node area is advocated but the prognosis is poor.

Dr. Telford — "G.P." of Year

Elbridge Wright Telford, M.D., of De Kalb, is the "General Practitioner of Illinois for 1956."

Dr. Telford is the eighth in an illustrious list of Illinois physicians who have been honored with this distinction by the Illinois State Medical Society. His citation will be presented at the annual meeting in May.

The selection of Dr. Telford was made by a special committee, the identity of which is never disclosed. Announcement was made to the press at that time, and his name was presented to the American Medical Association as a candidate for national honors.

Born in Washington, D.C., September 29, 1901, he is the youngest physician to receive this distinction. However, his 28 years of medical practice in De Kalb have made him a fitting selection.

He came to Salem, Ill., with his parents, at the age of 3, graduated from high school there, and received his medical degree from Northwestern University Medical School in 1925. He interned for six months at the Community Hospital, Geneva, and for two years at the Cook County Hospital, Chicago.

Taking up his practice in De Kalb in January 1928, he has served as a most conscientious and industrious practitioner. In 1933, he also became a Fellow of the American College of Surgeons, but he has not limited his work to surgery.

He is a past president of the De Kalb County Medical Society and has held important committee appointments during his entire period of

membership. Through his large industrial practice, he has been able to ease tensions between worker and employer on many occasions.

Dr. Telford has found time during a busy medical practice to participate in community affairs. He was chairman of the Civil Defense Committee and active in promoting that program. He has been prominent in the Boy Scout movement, Rotary, Chamber of Commerce, and veterans' organizations, and has been a prime mover for a medical arts building in De Kalb. He is a member of the Methodist Church, the Masons, and the Elks.

At the outbreak of World War II, he entered military service as a first lieutenant. He served 4½ years in the European and South Pacific theaters and came out a major. One of the organizers of the medical service of the 44th Division, Illinois National Guard, he returned to active duty in 1953 as a lieutenant colonel in that division. He went to Korea as division surgeon of the 45th Combat Division and served more than a year.

In submitting the name of Dr. Telford, the De Kalb County Medical Society said: "He is an able and conscientious man, a responsible man, a man who upholds the most honorable traditions of medicine, a man of whom our society is proud."

‹ ›

Prevention of rheumatic fever

The prompt treatment of streptococcal sore throat usually prevents the development of an attack of rheumatic fever in a susceptible individual. Penicillin is the drug of choice and all streptococci present must be eradicated. The wide spectrum antibiotics also are effective but not to the same extent as penicillin.

Treatment is continued for 10 days in adequate dosage to insure complete eradication of the organisms. This goes beyond the period of clinical cure. Stollerman[1] recommends the following schedules:

a) A single injection of 600,000 units of benzathine penicillin.

b) 600,000 units of procaine penicillin in oil with 2 per cent aluminum monostearate administered every other day for three or four days.

c) 250,00 units of penicillin by mouth three times daily for 10 days, preferably given on a fasting stomach.

The sulfonamides cannot ward off rheumatic fever, after a strep infection has occurred. They are used for long term prevention of rheumatic recurrences. The daily use of 1.0 gm. of sulfadiazine by mouth is recommended. Oral penicillin in daily doses of 200,000 to 250,000 has been used to a lesser extent.

More recently, Stollerman found the long acting repository penicillin compound, benzathine penicillin, highly effective in preventing streptococcal infections and rheumatic recurrences. A single intramuscular injection of 1.2 million units provides detectable penicillin levels for as long as three to four weeks. This plan calls for an injection every four weeks continuously throughout the years until the patient reaches adult life.

In adults, the injections are given for five years after the most recent attack. The expense, annoyance, and occasional indifference of the patient must be weighed against the fact that each rheumatic recurrence increases the danger of serious organic heart disease.

‹ ›

1. Stollerman, Gene H. Philadelphia Med. 50:1477 (1955).

Do you plan to build, remodel, or rent?

Besides making unsecured ten year loans to physicians seeking to establish practices, the Sears Roebuck Foundation, after consultation with the American Medical Association, has prepared a brochure as a *Planning Guide for Establishing Medical Practice Units.*

This brochure may be borrowed from the Secretary's Office, 224 South Main Street, Monmouth, upon receipt of a written request. Since the first announcement of the availability of this booklet, some 20-24 requests have been received, and the requests have been filled. There are several additional copies available for physicians interested. The brochure was financed by a grant from the Sears Roebuck Foundation and developed with the guidance and advice of a medical advisory board appointed by the A.M.A. It provides graphically and descriptively, a

check list for doctors who wish to establish a medical practice unit in a new building, in an existing building to be remodeled, or in a building or an office space to be rented.

It provides information for physicians setting up practices, expanding practices, or combining with other physicians to develop single medical units. The comparative advantages and disadvantages of building, remodeling, or renting are discussed, and all the factors involved in planning a medical unit are considered for the various specialties as well as for the general practitioner.

The eight basic elements in the planning of any unit are described: the reception room; the receptionist-control-station business office; the consultation room; the examining and treatment room; the laboratory (including electrocardiographic and basal metabolism apparatus); the X-ray and diagnostic room; the toilet; and the utilities and storage room. Drawings and explanations of each element, along with examples of how these various elements can be combined and expanded, are presented.

Specific aspects, involving heating, ventilating, air conditioning, plumbing, and wiring, are also discussed.

Actual management of practice, once the medical unit has been established, is considered in another section. Types of organization, division of income, retirement, sick benefits, death benefits, and settlement of estates are some of the subjects covered.

If you wish to borrow a copy of this pamphlet, address a request to the Secretary's Office, 224 South Main Street, Monmouth, Illinois.

‹ ›

The Illinois plan for the distribution of poliomyelitis vaccine *

The *voluntary co-operation* between the citizens, the physicians, and the public health workers of the State is needed to accomplish the task of getting as many Illinois children and pregnant women immunized against poliomyelitis as the vaccine supply will permit, before July 1, 1956.

Here are some of the problems that everyone must understand and appreciate before they can truly co-operate in the task:

1. The money appropriated by the Poliomyelitis Vaccination Assistance Act of Congress, which has been allocated to Illinois, plus the one million dollars appropriated by the Illinois State Legislature, will provide enough vaccine for about 35 per cent of the population of the state who would be eligible for the "free" vaccine under provisions of the Law. (Individuals who have not reached their 20th birthday and pregnant women.)

2. The national distribution system for all vaccine released by the manufacturers after approval of the Public Health Service requires that all states get a fair proportion of each lot of vaccine.

3. The vaccine now being manufactured has a relatively short potency period; it outdates within a period of 4 to 6 months. If it is not used within the specified time, it is lost. The allocation cannot be replaced by later releases.

4. The total output of approved vaccine between now and next spring cannot be accurately predicted, either as to quantity or as to time when it will be released.

5. The funds appropriated for the administration of the program are limited.

THE ONLY WAY THE OBJECTIVE CAN BE REACHED IS BY VOLUNTARY CO-OPERATION.

Allocation of "Free" Vaccine Supply

Federal allocation to the state is based on 2 cc. per eligible person to allow two inoculations of 1 cc. each with an interval of 3-4 weeks. Each lot of vaccine that is secured by the Illinois Department of Public Health will be allocated to each county and the City of Chicago on a percentage basis. The percentage has been determined by the estimated population of the jurisdiction under 20 years of age, and the 1950 census data on the median family income of the area.

It will be the prerogative of the Illinois Department of Public Health to reassign vaccine

From Illinois Department of Public Health; approved by the Illinois State Medical Society Committee on Poliomyelitis.

supplies that may become outdated to other areas in the state, so that they will not be wasted. The allocation will be replaced by vaccine or other lots, if available.

TO INSURE 100 PER CENT USAGE OF VACCINE ALLOCATED TO EACH COUNTY, THE VACCINE SHOULD BE INOCULATED INTO CHILDREN AS SOON AS IT BECOMES AVAILABLE.

Who Can Receive Poliomyelitis Vaccine Inoculations

1. The National Poliomyelitis Advisory Committee decides which age group is to have priority for the limited supply of vaccine—"free" or commercial supply. This age priority is determined by the age groups most susceptible to paralytic poliomyelitis, and the amount of vaccine available at the time. As this is going to print, the priority age group is 5 to 9 years. Two cc. are allocated per eligible child.

2. The American Medical Association and Illinois State Medical Society have gone on record as agreeing to adhere to this priority regulation for use of the vaccine. This means that physicians are expected to give all vaccine both purchased by them or issued to them from the State supply, to individuals in the current priority age group.

3. The Federal appropriation stipulated that vaccine is to be made available *without cost for the vaccine* for individuals under 20 years of age and pregnant women. As the supply increases, more ages will be included in the priority age group; however, the tax-purchased vaccine can be used only for the individuals designated by the Law.

Method of Distribution of the Poliomyelitis Vaccine Purchased by Federal and State Funds

1. The full-time health departments of the state will receive their total allocation of each lot of vaccine for distribution within their jurisdiction. It will be the responsibility of these health departments to provide vaccine for all orphanages, clinics organized for the care of low-income families, and to practicing physicians in their jurisdiction who request vaccine for inoculation of children, and to supervise any large group or mass program conducted in their jurisdiction.

The full-time health department will be required to make regular reports of the use of the vaccine, which will be needed to compile a state summary for the Federal Government. (This is required by the Federal Law.)

The full-time health department must notify the Bureau of Communicable Disease Control of the Illinois Department of Public Health at least 6 weeks before the outdate period of any vaccine on hand, which will not be used before the expiration date, so that it can be reallocated.

2. The Illinois Department of Public Health, Bureau of Communicable Disease Control, will distribute directly to physicians and orphanages, institutions, etc., the vaccine allocations for the counties and areas in the state not covered by full-time health departments. Physicians must apply for their vaccine on the forms provided and mail to the Illinois Department of Public Health, Bureau of Communicable Disease Control, State Office Building, Springfield, Illinois.

No mass or large group programs can be planned in these areas without first conferring with the appropriate regional office of the Illinois Department of Public Health and then making application to the Bureau of Communicable Disease Control. This is necessary to make sure that the total county allocation of vaccine will not be used in one school at the expense of other school districts of the county or other eligible age groups of the county. A county-wide committee for controlling the intra-county distribution of vaccine might be needed in some areas. The county medical societies should be the ones to decide this.

Assistance to Local Areas in Conducting Poliomyelitis Vaccination Programs

1. The Illinois Department of Public Health will assist, within the limits of its resources, any local area wishing to conduct special programs for inoculating eligible individuals with poliomyelitis vaccine, provided that they are approved by the appropriate medical society.

It must be kept in mind that the "free" vaccine allocation is limited, and that it is designated by law to be for only certain age groups, and cannot be given to individuals until they are on the priority age group. A program in a county that might use the entire allocation of "free" vaccine for a specific age group may deny worthy individuals of other age groups of assistance when they are included in the priority age group. Local groups planning to con-

duct large mass programs must be willing to supplement the state supply of "free" vaccine with locally purchased vaccine, if necessary.

Quick Reference for Doctors

1. You as an Illinois physician may request vaccine for your Illinois patients by filling out request forms provided, listing names and ages of children for whom you wish "free" vaccine. This request must be mailed or presented to the appropriate distribution center.

2. You may not request or receive "free" vaccine for children who are not on the current priority age group.

3. If current supply of vaccine allocated to your county has been distributed, your order will be kept on file to be filled as soon as another allocation is made.

4. The recommended dosage schedule as this goes to print in two inoculations of 1 cc. each three to four weeks apart, with a third inoculation six or seven months later.

5. You must keep accurate records of *all* poliomyelitis vaccine which you use. The information needed is:

a) Name and age of individual receiving inoculation.
b) Date and site of inoculation.
c) Manufacturer and lot number of vaccine inoculated.

A roster form of record will be provided for physicians without cost, if they wish to use this method of record keeping.

(Records are necessary to assist in immediately locating lots of vaccine which give untoward reactions; and to assist in location of lots of vaccine which failed to provide adequate protection against paralytic poliomyelitis during the 1956 season, and perhaps later.)

‹ ›

Postgraduate conferences in Illinois

The Illinois State Medical Society, through its Committee on Postgraduate Education, has been scheduling one day conferences in all parts of the state for approximately 18 years. During this period, there have been some 200 conferences scheduled through this Committee. We have been most fortunate to have the fine cooperation of our five medical schools, Veterans Administration Hospitals, and many of the larger hospitals in Chicago. These have furnished complete teams to present programs, in turn, at the conferences.

The first of the series for the fiscal year 1955-56, was presented at the Fayette County Hospital, Vandalia, on October 20. The staff of the Veterans Hospital at Hines sent seven members to present the scientific program. A complimentary luncheon was served, with the Fayette County Medical Society acting as host.

In arranging the conferences for the current series, a new plan has been developed whereby a member of the Postgraduate Education Committee will preside at the afternoon session. At the dinner and after dinner presentation, the president of the host society will preside. The Councilor for the district, following the dinner, will make a 15 minute talk on "Medical Organization Today." This will be followed by a scientific talk on a popular medical or surgical subject by a member of the guest team.

The second of the current series was presented October 27 at Jul's Danish Farm, on U. S. Route 30, a short distance from Sterling. The program was presented by 10 members of the faculty of Stritch School of Medicine of Loyola University. The Whiteside County Medical Society was the official host. Among the 10 speakers scheduled were the heads of the Department of Medicine and of Surgery from the Stritch School.

In recent years, the Committee on Postgraduate Education has been somewhat perplexed at the decrease in attendance at many of these meetings. A mailing list is made up of the physicians in all counties immediately surrounding the place of the meetings. Each receives an announcement two weeks before the conference, giving information relative to it and urging the physicians to attend.

A week later, an official program and return postcard addressed to the host society secretary is sent to the same mailing list, so that the physicians can let the secretary know if they expect to attend the meeting.

We are aware that there are many more meetings today than were held 10 or 20 years ago. Most of these, however, require travel of a considerable distance. The conferences in the home territory have been arranged to suit the rural physicians' convenience.

Another type of service through this com-

mittee was initiated last year. This is the so called circuit rider type of meeting. A competent clinician goes into a rural community and meets the local physicians in a hospital. Several of them have cases with a well prepared history, and perhaps X-ray, laboratory and other reports available for the clinician to go over with them. Occasionally, patients are sent to the hospital for a short period so that they can be seen and made the subject of discussions before the small group at the conference.

This has proved to be a popular type of conference and it will most likely be used oftener during the current fiscal year. A careful check on attendance at the 1955-56 conferences will be kept, and the State Medical Society will be able to determine whether circuit rider meetings will be arranged in future years. The expenses of the speakers, printing, postage, and mailing are paid by the State Society, which is desirous of giving members the type of services they most desire.

For the current series, another change in the arrangement has been made in that for every presentation some physician in the local area has been selected in advance to lead the discussion.

Dr. Louis R. Limarzi, Chicago, is chairman of the Postgraduate Education Committee, and Dr. George E. Kirby, Spring Valley, is Co-Chairman. The Committee is made up of members from all parts of the state. The entire committee gets together on several occasions during the year to make plans for a more successful series for the year, and they always welcome suggestions from any member of the Illinois State Medical Society.

It is hoped that the current series of Conferences will be better attended than those of recent years, so that the House of Delegates at the next annual meeting will again ask that they be held during the next fiscal year.

‹ ›

Knowledge alone does not stop men from evil. The poor and the ignorant are not the greatest sinners. Man's mind may unfold, his intellect grow more keen, his understanding more profound, yet side by side with this may be a moral degeneration such as existed in pagan Greece and Rome.

William A. Scully, D.D.

The woman's auxiliary

The Woman's Auxiliary to the Illinois State Medical Society wants to be represented in every county in Illinois.

The County Medical Societies in Illinois, collectively, are the Illinois State Medical Society. The medical profession in Illinois reflects the collective reputation of Medicine in each community. Service, like charity, begins at home. Our greatest impact is through intelligent, informed, individual and group action in our own communities.

By uniting, we can learn about and be instructed in medical matters of interest to the public. We can disseminate correct information through the various civic and social clubs with which we are affiliated. Organization is the difference between the solo and the choir. While the solo is beautiful and effective, the choir is compelling and powerful. The Auxiliary's potential as an ally to the Medical Society is in direct ratio to Auxiliary strength in numbers.

The authority for an Auxiliary comes from the Medical Society. Our incentive is a sincere desire to be a part of a great profession, because you tell us that our efforts are needed, because you know our loyalty is without question.

Members of the Auxiliary are privileged to:

Assist the Medical Society in its program for the advancement of medicine and public health.

Cultivate friendly relations and promote understanding among physicians' families.

Serve as leaders of health education in the community.

Act as liaison between the medical profession and the public.

Contribute to the Benevolence Fund.

Membership in the Illinois State Medical Society is 9,894. Auxiliary membership is 2,581. County Medical Societies are represented in 95 counties; County Auxiliaries, in only 41 counties. Eight hundred doctors' wives in counties not having Auxiliaries and more than five thousand doctors' wives living in counties where Auxiliaries exist do not belong to an Auxiliary.

Organization involves increasing and strengthening membership in existing Auxiliaries, creating Auxiliaries to County Medical Societies where it is feasible, and enrolling Members-at-

Large where it is impossible to organize an Auxiliary.

Medicine must maintain its own direction. The enormity of this responsibility demands the co-operation of every doctor and his wife. This is "complete organization." Can we afford less?

Organization is everybody's business. It is the specific assignment of the President-Elect and the Councilors listed below, each of whom will work diligently to help establish an Auxiliary in your County, or to assist in increasing membership at your request.

First District: Mrs. J. S. Lundholm, Rockford
Second District: Mrs. Charles LeSage, Dixon
Third District: Mrs. Lewis Hare, Chicago; Mrs. H. Close Hesseltine, Chicago; Mrs. H. Kenneth Scatliff, Evanston
Fourth District: Mrs. F. E. Bollaert, East Moline
Fifth District: Mrs. Daniel D. Raber, Normal
Sixth District: Mrs. George Vernon, Edwardsville
Seventh District: Mrs. H. E. Schoonover, Salem
Eighth District: Mrs. W. F. Lantz, Danville
Ninth District: Mrs. Douglas Lehman, Harrisburg
Tenth District: Mrs. G. H. Edwards, Pinckneyville
Eleventh District: Mrs. Earl S. Leimbacher, Joliet

Mrs. Robert E. Dunlevy
Organization Chairman

‹ ›

Booklet on indigent care plans

The Journal of the A.M.A. over the last three years published current information on 18 representative and successful state and local indigent care plans. These articles provided a guide for the establishment of programs elsewhere.

Now, the A.M.A.'s Council on Medical Service is to include these articles in a booklet, copies of which will be obtainable from the council upon request.

The booklet will contain studies of the following plans: State—Illinois, Rhode Island, New York, Pennsylvania, Maryland, Washington and North Carolina; local—Buffalo, Madison, Newark, Topeka, Gary, Cheyenne, Great Falls, Des Moines, Richmond, Evansville, and Fort Wayne.

Early medical public relations in Illinois

Recent writers on the subject of medical public relations who insist this is a relatively new project for medical societies evidently were not aware that Illinois doctors have been concerned with the problem for more than a century.

A chapter in Volume II of "History of Medical Practice in Illinois" (*), written by Mrs. Frances C. Zimmer, executive assistant to Dr. Harold M. Camp, secretary of the Illinois State Medical Society, is replete with incidents which arose in the early days of the organization.

The founding fathers were aware of the need for public relations from the very beginning because in 1850, when they wrote the preamble to the first Constitution and By-Laws, they included among the Society's purposes this significant phrase:

". . . . enlightening and directing public opinion in regard to the duties, responsibilities and requirements of medical men."

The first Code of Ethics also dealt with the problem because under the high standards demanded of the profession there was stressed the duty of doctors to the public.

There was no public relations bureau to present the good side of medicine before the people. Instead, the doctors worked hard to improve the practice of medicine so that the patient would benefit.

They campaigned for better medical education and higher qualifications of those who served as physicians. They worked hard in the interest of public health, public welfare, mental health, sanitation, and control of communicable deseases. They took positive stands in matters before the legislature and assumed community duties. Quackery was exposed.

All these efforts were duly noted and medicine was regarded in a better light. However, the House of Delegates recognized that steps should be taken to bring these activities to more public attention. By 1865, the House voted that the official transactions should be published in leading newspapers of the state. Members of the House also were encouraged to seek favorable newspaper comment on what the profession was doing.

*Published by the Illinois State Medical Society, a book which should be in every doctor's library.

Five years later, in a publication of the Constitution and By-Laws and the Principles of Medical Ethics, we find an admonition to doctors:

"As good citizens, it is the duty of physicians to be ever vigilant for the welfare of the community and to bear their part in sustaining its institutions and burdens; they should also be ever ready to give counsel to the public in relation to matters especially appertaining to their profession, as on subjects of medical policy, public hygiene, and legal medicine."

Dr. J. L. White, in his presidential address in 1878, also touched upon the duty of doctors toward their community when he said:

"It is to be hoped we may go from this session of our Society inspired not only with fresh zeal in the performance of our duties, but also with a renewed sense of the obligations we are under to discharge faithfully the duties of citizenship, and with a feeling of gratitude that our lives have fallen in such pleasant places."

Today, the medical profession hears complaints that there is overspecialization and that the doctor has lost his close personal touch with the patient. These are looked upon as developments in comparatively recent years. It may come as a distinct surprise that the same problem plagued the doctors in 1882.

In that year, Dr. Robert Boal of Peoria, one of the founders of the Society, in his presidential address, reviewed the history of the previous 50 years. He said:

"History contains no record of a people whose progress has been so rapid and marvelous as our own. Then the practice of medicine in all departments was pursued by the same individual. Now we have specialists in every branch of the science and art of medicine. . . .

"Then the doctor, next to the minister, was the trusted friend and counselor of every family to whom he ministered. He shared their joys, soothed their sorrows, and every passing year added to and cemented the attachment and affection between them.

"Now the doctor is regarded more in the light of a tradesman or mechanic, and is employed from the same considerations that a grocer, tailor or shoemaker is. The strong ties of gratitude and affection have almost ceased to exist. Relationship is now placed upon a mere commercial basis, and for this the profession is more to blame than the public."

All through the last half of the 19th century, physicians were urged to take an interest in legislation and to influence public opinion. However, Dr. J. W. Pettit of Ottawa, in 1898, commenting on a then pending medical practice act sounded a note of warning which still holds good.

Dr. Pettit pointed out that the "principle of protection to the public must constantly be kept in view and any departure from it will nullify any law we may succeed in having enacted."

All this sounds like today, doesn't it?

‹ ›

Clinical meeting of A.M.A.

The Clinical Session of the American Medical Association in Boston, November 29-December 2, will offer physicians an excellent post-graduate course. There will be plenty of social events to occupy the time of wives who may accompany their husbands. And, if the doctors are so inclined, Boston's historic landmarks are well worth a visit.

For the physician, an outstanding scientific program will be provided. This will cover all phases of medicine. There will be presentations of papers, round table discussions, color television, and medical motion pictures.

Leading authorities from all parts of the country will present scientific exhibits and be on hand to answer questions and to discuss problems. The latest developments in equipment, books, and pharmaceuticals will feature the technical exhibition.

Sessions of the House of Delegates and the scientific meetings will be held in the Statler Hotel. Exhibits will be staged in the Mechanics Building.

‹‹‹ ›››

John R. Wolff, Chairman, Walter C. Bornemeier, Edward W. Cannady, Roland R. Cross, Jr., E. F. Dietrich, W. W. Fullerton, Edwin F. Hirsch, Frederic T. Jung, W. R. Malony, Caesar Portes, William Requarth, Frederick W. Slobe.

Public Relations

CAESAR PORTES, M.D., CHICAGO

OUR public relations or our relations with the public seem to be at a low ebb. Every one likes to take a "sock" at the doctor. The lawyer, merchant, chief — yes, even the doctor takes a "sock" at his colleague. Why? Why does the public like to criticize the medical profession? What is the reason for their complaints? Some complaints are no doubt valid but many are unwarranted. I think the root of the trouble is misunderstanding.

Our public relations committees have been on the defensive. It is about time we took the offensive. We should talk back to people who criticize us. We should publicize the good deeds of the medical profession and deny the false charges. We should reply at once to the articles published in the press and rebut the incriminations.

The public must be awakened and their memories refreshed to the fact that there is no other profession like the medical profession. Before one even begins to study medicine he must have a deep rooted love for the profession. He must want to do good for humanity. Financial benefits are of secondary importance.

What other profession gives of itself as does the medical profession? Most doctors give a great part of their time and effort to the care of the poor, the indigent. Many devote time to teaching clinics; they treat the sick without asking for pay; fees are a secondary consideration. The medical profession is primarily concerned about the health of the citizens, of their city, the state, and the nation.

Our public relations were not at their best in our dealing with the National Polio Foundation; it didn't improve visibly in the publicity associated with the polio vaccine incident.

The Chicago Medical Society, at its Council meeting, was very much against mass inoculations of children with polio vaccine. They felt that it would be best for the children if their own pediatricians or family doctors treated them. In fact, a motion was passed at this council meeting that the doctors were willing to give their services gratis, yet an announcer on one of the TV programs had the audacity to state that the Chicago Medical Society opposed the National Foundation for Infantile Paralysis because of the money involved and used the expression that the society "still wants its pound of flesh." How dare he say that and go unchallenged, he who makes a living peddling nostrums on TV and radio; the questionable patent medicine and quack remedies that may hurt the public! He who makes a living selling those drugs dares to criticize the doctor who only looks toward improving the health of his fellowman.

Yes, our public relations should go further and expose some of these nostrum peddlers, stop them from selling *to the innocent public* medicines, drugs, and the like which may be harmful.

What are the gripes of these critics? What are their grievances, they are usually unfounded,

due to their ignorance of the good qualities of the medical profession. The public relation committees should institute a program of publicity. They should inform the public that we have grievance committees—every county medical society has a grievance committee ready and willing to listen to any criticism. There is no need to blast the newspapers and magazines with articles that contain unfounded facts. Any grievance against one or many doctors can easily be thrashed out in the office of the local medical society.

Public relations represent a big job. It is a necessary job. It begins in the individual doctor's office. It is nothing else but an effort to establish good friendly relations and understanding with the patient. However, it must be well organized and presented to the public in an understandable form. We must have public relations committees, but the individual doctor is a public relations committee in himself.

25 E. Washington St.

‹‹‹ ›››

The modern allergist

The allergist of today is a specialist in the treatment of diseases based on the mechanism of hypersensitivity. This group of diseases is increasing almost daily. We are not merely internists who treat hay fever and asthma, nor are we just pediatricians who treat these diseases. Our field embraces practically every organ of the body and we must recognize allergic disease of the eye as well as of the skin and of the lungs. Since hypersensitivity diseases are frequently affected by nonspecific factors such as infections, emotions, and glandular misfunctions, we must be experts in infectious diseases, we must be conversant with psychiatry, we must be good practical endocrinologists. We are internists and pediatricians; we are otolaryngologists, dermatologists, and immunologists. Our province includes occupational disease problems and medicolegal aspects of such diverse fields as air pollution and skin sensitization phenomena. The place of allergy in the broad field of medicine then is that of an independent specialty requiring specific training and experience in somewhat unrelated fields. Obviously, the practice of allergy has reached a stage where an independent board of its own is indicated. An "American Board of Allergy" would encourage younger men to enter the specialty, for it would bring about proper recognition of the greatly increasing and interesting field. An "American Board of Allergy" would set up standards of training and experience; it would examine and qualify specialists in the practice of allergy. Part-time allergists would continue to deal with symptoms of seasonal inhalant allergic disease. The specialist, a diplomate of the "American Board of Allergy" would rightfully take his place in the framework of medical specialists as the physician most qualified to care for the patient who, for some reason, perhaps hereditary, is subject to a variety of illnesses affecting any organ of the body and based on the phenomenon of hypersensitivity. *Norman Shure, M.D. The Place of Allergy in Medicine. California Med. July 1955.*

‹ ›

Deterioration plus

Individuals, like empires, may deteriorate from self-induced inner rottenness. Faulty nutrition, prolonged exhaustion, overweight, and needless infections speed up expenditure of vital body reserves. *Edward L. Bortz, M.D. Stress and Aging. Geriatrics. March 1955.*

THE P. R. PAGE



How to educate physicians

Dr. G. Wilse Robinson Jr., editor of the Jackson County (Mo.) Medical Society's "Weekly Bulletin," comes up with a fine suggestion.

Dr. Robinson points out that the A.M.A. and the state societies are the targets of medicine's opponents because these groups are out fighting to protect the profession against political control. If those organizations are discredited, then the doctors will have lost.

On the other hand, the individual physician, he says, has been rather disinterested. Yet, the individual doctor is all powerful if he will only get out and convince his patients and his friends that his position is the right one. Many a vote can be swung to our side.

The problem is how to get physicians to take more interest in affairs which concern their future. Too few pay attention to information and recommendations published in medical journals—if they read it at all. Dr. Robinson makes this suggestion:

"We all know that the hospital staff meetings and the specialty societies are very well attended. Why cannot these groups give five minutes at each meeting so that an officer of the society who is a member of that staff or association, or an officer of the group itself, could read a short summary of the current pressing problems facing us at the moment and inform the members present as to where the details can be found? Perhaps if a physician knew exactly where to find the answers, he would look them up."

‹ ›

A Project for Auxiliaries

C. Joseph Stetler, director of the A.M.A. Law Department, speaking before the fall conference of the Woman's Auxiliary to the Illinois State Medical Society, said that the auxiliary probably will be called upon in the coming year to use its full force in connection with four pending Congressional measures.

One would be to obtain support for the Bricker amendment which would limit the treaty making power of the President. It has been pointed out that under the existing laws, socialized medicine can be imposed on this country through the "back door."

A second is backing for the Jenkins-Keogh bills, which would establish a voluntary retirement plan for the self-employed. Present Social Security laws discriminate against the physician.

Medicine will be faced with a hard battle when the Senate takes up the bill providing cash benefits for disability, a lowering of the pension age for women, and liberalization of the Social Security Act in other ways. The measure passed the House in "blitz" fashion just before adjournment. Passage in the Senate and a Presidential signature would put the government firmly into medical practice. The auxil-

iary's help will be needed to generate public opposition.

The fourth measure is the reinsurance bill. This would permit the government to assume part of the risk of health insurance underwriters. Insurance companies as well as the medical profession see inherent dangers in this proposal.

When the auxiliaries are called upon to exert their influence, they should be ready to go into action immediately. There will be little time to organize them for public relations campaigns. The groundwork should be laid now. Committees should be set up, be fully informed of the problems which will face them, and be prepared to move. The opposing forces are well organized now.

‹ ›

Doctors and Traffic Safety

County medical societies in many parts of the country are taking considerable interest in traffic safety problems in their respective communities. Presenting constructive suggestions, the results are improved public relations.

Doctors are well qualified to point out the terrific consequences of traffic accidents. They can tell of the medical and surgical problems caused thereby and of the economic loss. These explanations often can take a dramatic form.

For instance, in Warrenton, Va., two physicians and an embalmer went before the highway department and told how "profitable" was the lack of a stoplight at a dangerous intersection. It worked.

Almost every town has some point where there are frequent accidents. County societies can take an interest in correcting the conditions. Community newspapers are always glad to have such action as a peg on which to hang a story or to back up an editorial position.

The national traffic toll is a terrible one—38,000 killed annually, 2,000,000 injured, and an economic waste of $4,300,000,000. County societies and auxiliaries can't go wrong when they incorporate in their programs a move to bring about a reduction in this cost.

‹ ›

Letters to the Editor

Newspapers and magazines sometimes will publish an article about a cult, or some other subject, to which the medical profession may take exception. But, if this exception is made for publication, the wording had best be weighed carefully. Point out the inaccuracies, if there are any, but don't assail the newspapers for having printed the article, or question the motives. It may boomerang.

Just to give an example. Recently, a newspaper carried a feature, illustrated story in its "Green" section about a chiropractic clinic. A medical society executive sent a blistering letter to the editor, saying that "the color of the page was most appropriate to the contents of the article." The writer also asked the question: "Since when has it become the practice of the . . . . . to print such personal-laudatory articles without advertising charges?" Some inaccuracies were cited.

The letter was published in full, but the next day the newspaper devoted twice as much space to an editorial in which it berated the medical profession most unmercifully. The editorial also rightfully raised the point that there is no objection when the medical profession received some free advertising.

Newspaper editors as a rule will allow a reader to express his opinion on a subject. Thus, you can get your views before the public. But, don't attack the newspaper itself. It always has the last word. You can't win.

‹ ‹ ‹ › › ›

CORRESPONDENCE



Blue cross increases benefits and membership dues

A total of 120 days of benefits per accident or illness will be given to Comprehensive and Co-operative members of the Blue Cross Plan of Hospital Service Corporation with headquarters in Chicago, beginning with hospital admissions on and after November 1, 1955.

Still another increased benefit offered to Co-operative and Comprehensive members will be the provision of the benefits of this Plan in any of the 6,000 Blue Cross hospitals in the United States and Canada, and in recognized hospitals in foreign countries or in areas not served by any Blue Cross Plan. This means that there will be but a very few non-Plan hospitals where the previous non-Plan allowances will still apply.

Substantial increases in the cost of hospital care and a continually increasing percentage of members going to hospitals which the Plan has experienced in the 2½ years since the last rate raise, made an increase in dues necessary. At the same time, in answer to public demand, it was decided to add these two important benefits.

Group members of this Blue Cross Plan who have co-operative certificates will now pay $2.32 for individual membership and $6.32 for family membership while Comprehensive subscribers will pay $2.56 for individual membership and $8.24 for family membership. There is no change in dues or benefits for Blue Shield members of Illinois Medical Service, which is offered as a companion plan to Blue Cross.

Under the new program, members may receive up to 120 full days of hospital care benefits for each illness or accident, instead of the 30 full and 90 half days per calendar year as in the past.

Here's how the new 120-day Plan works: A member of either the Co-operative or Comprehensive Plan may go into the hospital for a serious heart condition and receive 120 days of care. Then if he is discharged from the hospital and is injured in an auto accident on the way home, he may be admitted to the hospital again and receive another 120 days of care.

And when a period of 90 days separates discharge from and readmission to a hospital, a member may receive 120 days of benefits again for the same or related condition. Thus, the member with the heart condition could receive Blue Cross benefits again after he had been out of the hospital for a period of 90 days. And he is in benefit over and over again without any waiting period between for all entirely different conditions or accidents.

This Blue Cross Plan paid for 315,827 hospital bills last year, totalling $38,090,523. An average of 5,855 Plan members were in the hospital every day last year.

‹ ›

A.M.A. official tour to Nassau

Following the A.M.A. Clinical Session in Boston, many members of the A.M.A. will join an official tour to Nassau, leaving Boston on December 2 from the Hotel Statler. The first stop will be the Waldorf Astoria Hotel in New York.

At noon on December 3 the party will board a BOAC Stratocruiser flight, "The Bahamian",

with arrival in Nassau early enough for an evening of planned entertainment.

Physicians will receive a certificate of attendance for a special medical meeting scheduled for December 7 at the Jungle Club in Nassau. Invitations to the meeting have been extended by the Bahamas Medical Association, and the President, Dr. Kenneth Eardley, has prepared a seminar program designed to present current problems of medical practice in the Bahamas.

The week's calendar in Nassau is filled with personal entries, and special functions planned for physicians and their wives. Many will find Nassau ideal for Christmas shopping with an array of European imports at prices substantially below those in the United States.

The party will leave Nassau for Miami on one of BOAC's new Viscounts on December 10, with connecting flights available to home cities in plenty of time to be back in offices by Monday, December 12.

Official tour folder giving complete information may be secured by writing to A.M.A. Nassau Tour Headquarters, 33 East Monroe Street, Chicago 3.

‹ ›

American Goiter Association

Jack E. Kearns, M.D., of Evanston, has been named as Chairman of the Public Relations and Publications Committee of the American Goiter Association, which will hold its annual meeting at the Drake Hotel, Chicago, May 3-5, 1956. The meeting will be open to the general medical profession.

Further information will be published in the Illinois Medical Journal at a later date. If specific data are desired, write to Dr. Kearns at 636 Church Street, Evanston.

‹ ›

Chest physicians essay contest

The Council on Undergraduate Medical Education of the American College of Chest Physicians offers three cash awards to be given annually for the best contributions prepared by undergraduate medical students on any phase in the diagnosis and treatment of chest diseases (heart and/or lungs).

The first prize will consist of a cash award of $250.00; second prize will be $100.00; and third prize, $50.00. Each winner will also receive a certificate of merit.

The winning contributions will be selected by a committee of chest specialists and will be announced at the 22nd Annual Meeting of the American College of Chest Physicians to be held in Chicago, Illinois, June 7-10, 1956. All manuscripts become the property of the American College of Chest Physicians.

Applicants are requested to study the format of *Diseases of the Chest,* the official journal of the College, as to length, form, and arrangement of illustrations to guide them in the preparation of the manuscript. A copy of the College journal will be sent upon request. The following conditions must be observed:

The completion of an application form, which may be obtained by writing the Executive Director, American College of Chest Physicians, 112 East Chestnut Street, Chicago, 11, Illinois.

Five copies of the manuscript typewritten in English (double spaced) should be submitted to the College offices in Chicago not later than April 10, 1956.

The only means of identification of the author shall be a motto or other device on the title page and a sealed envelope bearing the same motto on the outside, enclosing the name and address of the author.

‹ ›

Fellowships in industrial medicine

The University of Cincinnati's Institute of Industrial Health is offering graduate fellowships in Industrial Medicine. The Institute, which is in the College of Medicine, provides professional training for graduates of approved medical schools who have completed at least one year of internship.

The three-year course of instruction, leading to the degree of Doctor of Science in Industrial Medicine, satisfies the requirements for certification in Occupational Medicine by the American Board of Preventive Medicine. Two years are devoted to intensive academic and clinical study in the field of industrial medicine. A final year is spent in residency in an industrial medical department or in some comparable organization.

Stipends for the first two years vary from $3,000 to $4,000 depending on marital status. In the final or residency year a fellow is compensated by the organization in which he is completing his training.

A one-year certificate course, without stipend, is also offered to qualified applicants.

Requests for additional information should be addressed to Secretary, Institute of Industrial Health, College of Medicine, Eden and Bethesda, Cincinnati 19, Ohio.

‹ ›

Clinics for crippled children listed for December

Seventeen clinics for Illinois' physically handicapped children have been scheduled for December by the University of Illinois Division of Services for Crippled Children. The Division will count 10 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social and nursing service. There will be five special clinics for children with rheumatic fever and two for cerebral palsied children.

Clinics are held by the Division in cooperation with local medical and health organizations, both public and private. Clinicians are selected among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

The December clinics are:

December 7—Rock Island (Cerebral Palsy), Foss Home, 3808 8th Ave.
December 7—Hinsdale, Hinsdale Sanitarium
December 8—Springfield, St. John's Hospital
December 8—Elmhurst (Rheumatic Fever), Memorial Hospital of DuPage County
December 9—Chicago Heights (Rheumatic Fever), St. James Hospital
December 13—E. St. Louis, Christian Welfare Hospital
December 13—Fairfield, Fairfield Memorial Hospital
December 13—Peoria, Children's Hospital
December 13—Effingham (Rheumatic Fever), St. Anthony's Hospital
December 14—Alton (Rheumatic Fever), Alton Memorial Hospital
December 14—Springfield (Cerebral Palsy), Memorial Hospital
December 15—Rockford, St. Anthony's Hospital
December 16—Chicago Heights (Rheumatic Fever), St. James Hospital
December 20—Peoria, Children's Hospital
December 21—Chicago Heights, St. James Hospital
December 22—Bloomington (A.M.—General; P.M.—Cerebral Palsy), St. Joseph's Hospital
December 28—Elgin, Sherman Hospital

‹ ›

Physical therapy examination

The State Department of Registration and Education announce that they have scheduled a Physical Therapy Examination to be held in Chicago on Friday, December 16, 1955. Complete details may be procured from this Department in Springfield.

Vera M. Binks, Director
Frederic B. Selcke
Superintendent of Registration.

‹‹‹ ›››

NEWS of the STATE



ADAMS

Society News.—Dr. Falls B. Hershey, chief of surgery, St. Louis Veterans Administration Hospital, addressed a dinner meeting at the Adams County Medical Society, September 12, 1955, on "Arterial Surgery with Special Reference to Arterial Grafts."

New Television Series.—The Adams County Medical Society inaugurated a television series, November 20, on the Hannibal-Quincy station KHQA, Channel 7, when Dr. George Borden, Quincy, discussed "Mental Health." Others in the series will include Dr. Clare Miller, December 18, on Tuberculosis; Walter M. Whitaker, January 15, on Poliomyelitis; Warren F. Pearce, February 19, Heart Disease; Roger G. Clarke, March 18, on Diabetes, and Newton Du Puy, April 15, on Cancer. The series is being presented under the auspices of the Public Relations Committee of the county medical society.

New Physicians in Quincy.—Dr. William U. McReynolds has begun practice in association with Dr. Carson K. Gabriel. He will confine his work to ophthalmology. Dr. George W. Shannon has joined Dr. Harry G. McGavran in the practice of urology. Dr. Donald M. Wright has joined the department of otolaryngology of the Physicians and Surgeons Clinic.

COLES-CUMBERLAND

Educational Program for Ambulance Drivers.—The Coles-Cumberland County Medical Society recently established a Trauma Committee to inaugurate an educational program for all ambulance drivers in the area, according to information from Dr. Stanley W. Thiel, secretary of the society. The program will include a series of instructions on the care and handling of injured patients by the ambulance drivers. At the first meeting in September all of the ambulance services expressed approval and enthusiasm of the program, which is under the direction of Dr. Edward N. Zinschlag, Mattoon, and Dr. Clinton D. Swickard of Charleston. The first meeting was concerned with care of fractures of the extremities. All ambulances will now carry proper splints and the personnel have been instructed in the proper application of these splints.

COOK

William Cubbins Honored.—Dr. William R. Cubbins, 81, a member of the Northwestern University Medical School faculty for 34 years, was honored October 11, at a dinner in the Tavern Club. He was presented with a citation, signed by Dr. J. Roscoe Miller, president of the university, and Dr. Richard H. Young, dean of the medical school, which praised Dr. Cubbins "for lifelong devotion to medicine and service to the community and nation." Dr. Cubbins, who graduated at Northwestern University in 1900, is a former president of the university Alumni Association. A founder of the American College of Surgeons, Dr. Cubbins was also chief of the surgical staff at Cook County Hospital for 12 years, and later served as a member of the staff at Chicago Wesley Memorial and St. Luke's hospitals. According to the Chicago Tribune, he was affectionately known to a generation of medical students as "Dr. Bill."

Dr. Bird Joins Chicago Faculty.—Dr. H. Waldo Bird, Detroit psychiatrist and former member of the faculty at Wayne University College of Medicine, has joined the faculty of the University of Chicago School of Medicine as associate professor of psychiatry. Dr. Bird's major interest is convulsive disorders. He was active in the formation of the Michigan Association for Epilepsy, serving as chairman of the organizational development committee. He was also psychiatric consultant and chairman of the research committee of the Michigan Epilepsy Center. Dr. Bird also served as chairman of the Committee on Mental Health of the Michigan State Medical Society.

New Research Laboratories for Conditions of the Lungs.—Plans for new research laboratories for the study of disease of the lungs, heart, kidneys, and blood vessels were announced September 22 by Northwestern University Medcal School. The plans call for specially designed and equipped laboratories, examination and treatment rooms, and facilities for nursing care and social service on the third floor of the Montgomery Ward Building at the Northwestern University Medical Center on the Chicago campus.

"The functions of the heart, lungs, and kidneys are closely related in many ways," said Dr. Arthur R. Colwell in announcing the project, "and so are the diseases which affect them. A team approach is needed to study their complex interrelationships and to co-ordinate the investigation of the diseases and their diagnosis and treatment." Research investigators, practicing physicians, specialists, medical students, nurses, and social workers will cooperate in the project. Additional chemical and bacteriological studies will be conducted in the laboratories of the new Morton Medical Research Building.

Chest and circulatory diseases are the leading causes of death, claiming more than 750,000 lives in America each year. The new medical unit will be devoted to research studies designed to advance our understanding of these diseases, education to provide physicians with new knowledge to fight them, and improved treatment to aid those who are afflicted.

Patients will be studied in the clinic as "outpatients" rather than being confined to a hospital. This will make it possible to study chronic diseases in an early stage and to follow a patient's progress for years if necessary.

Special equipment for diagnosis and research will include a treadmill, used in testing the efficiency of heart and lung function under varying degrees of rest, exercise, and stress. Oxygen consumption is measured from collections of the air that the subject breathes while exercising.

Equipment will also include electrocardiographs, a ballistocardiograph, X-ray and fluoroscope units and heart catheterization equipment.

Personal.—Dr. Henry T. Ricketts, professor of medicine, University of Chicago School of Medicine, was elected president of the American Diabetes association at its recent meeting in Atlantic City.—Dr. Harold C. Lueth has been promoted by the Illinois Military District to the rank of brigadier general in the Army Reserve.

Special Lectures.—The Second Dallas B. Phemister Lecture was delivered October 28, by Dr. C. F. W. Illingworth, Regius Professor of Surgery at the University of Glasgow, on "Some Recent Researches on Peptic Ulcer."—The 27th Annual Arthur Dean Bevan Lecture of the Chicago Surgical Society was presented October 7, at the Knickerbocker Hotel.—Dr. Owen H. Wangensteen, professor of surgery at the University of Minnesota School of Medicine, Minneapolis, was the speaker on Current Accomplishments in Cancer of the Alimentary Tract With Special Reference to the Stomach and Colon."—Prof. E. Dahl Iversen, professor of surgery, University of Copenhagen, Denmark, gave the annual Charles H. Mayo Memorial Lecture at Northwestern University Medical School October 26. His subject was "The Function of the Endocrine Glands During the Postoperative Period."

Promotions at Northwestern—Among the promotions on the medical faculty at Northwestern University Medical School recently are the following: Dr. Alfred Biggs, Chicago, associate professor of pediatrics; Dr. Samuel H. Bluefarb, Chicago, associate professor of dermatology; Dr. Craig Borden, Chicago associate professor of medicine; Dr. T. Howard Clarke, Park Ridge, associate professor of surgery; Dr. Clinton Lee Compere, Evanston, associate professor of orthopedic surgery; Dr. John E. Kearns, Jr., Kenilworth, associate professor of surgery; Dr. Albert Milzer, Chicago, associate professor of bacteriology; Dr. John Ruger Norcross, Glenview, associate professor of orthopedic surgery; Dr. Meyer A. Perlstein, Chicago, associate professor of pediatrics, and Dr. Vernon Clifford Turner, Evanston, associate professor of orthopedic surgery.

Lecture Series.—"The Physician Looks at Social Problems" is the title of a series of lectures which opened at the Chicago Medical School October 11, with a lecture by Herman Finer, D.Sc., professor of political science, University of Chicago, with a presentation entitled "The Physician Looks at Social Problems." Others in the series are: Frank W. Durzenski, Agent, Bureau of Narcotics, U. S. Treasury Department, Chicago, October 18, on "Narcotic Addiction"; Edwin J. Holman, LL.B, Law Department, American Medical Association, November 1, on "Euthanasia, Artificial Insemination, and Sterilization"; Wilber G. Katz, professor of law, University of Chicago, November 8, on "Responsibility and Crime"; Elizabeth L. Breckinridge, Consultant on Aging, Illinois Public Aid Commission, November 15, on "The Problems of Aging"; Joseph D. Lohman, Sheriff of Cook County, November 22, on "Juvenile Delinquency"; and Robert M. Kark, M. D., professor of medicine, University of Illinois College of Medicine, November 29, on "International Social Aspects of Alcoholism".

Gift for Research on Multiple Sclerosis.—Northwestern University Medical School has received $25,000 from the Multiple Sclerosis Foundation of America to conduct research on the disease. The fund will be used to support research in progress as a team project among five departments at the school.

Dr. Lewis J. Pollock, emeritus professor and chairman of the department of neurology and psychiatry, is in charge of the program. Phases of the studies are being done in the department of biochemistry by Dr. Smith Freeman, professor and chairman of the department, Dr. Norman Radin, assistant professor, and Dr. E. A. Zeller, professor.

Other research is being carried on by Dr. Harry B. Harding, associate professor of bacteriology, by Dr. William Wartman, professor and chairman of the department of pathology, and by Dr. Derrick Vail, professor and chairman of the department of ophthalmology.

Multiple sclerosis is a crippling disease of the nervous system. More than 300,000 Americans now have it. The cause is not known and there is no known cure.

The Multiple Sclerosis Foundation of America has given $125,000 to Northwestern University in the past five years for studies that might yield information toward finding the cause of the disease or a treatment for it.

Attempts are being made to isolate and identify any infectious agent that might be the cause of multiple sclerosis and attempts are being made to cultivate central nervous system cells in chick embryos for the purpose of trying to infect them from multiple sclerosis patients. Sensitive tests devised at the medical school for the determination of small amounts of enzymes in the spinal fluid are being used to establish whether enzymes play a role in causing the disease. Biochemical and histologic studies are being done on the body fluids and tissues of multiple sclerosis patients and patients without multiple sclerosis to try to find differences to point to possible mechanisms involved in the disease. Various drugs are being tested for the treatment of multiple sclerosis and the manifestations of the disease in the eyes are being studied.

Memorial to Dr. Hektoen.—The Institute of Medicine of Chicago will meet jointly with the Society of Medical History of Chicago and the Chicago Pathological Society November 14, at the Palmer House. The meeting will be considered a memorial to Ludvig Hektoen. A feature of the evening will be the presentation of the sixth Richard H. Jaffe Memorial Lecture. by Esmond R. Long of the Henry Philipps Institute of the University of Pennsylvania. His subject will be "Old and New Concepts of the Pathogenesis of Pulmonary Tuberculosis.

Awards to Medical Students and Graduates.—Awards for high scholastic averages and meritorius research were recently presented to five medical students and graduates of Northwestern University Medical School. Dr. Arthur L. Norins, Park Ridge, was the winner of the Borden undergraduate research award in medicine. This award of $500 and a certificate is given to a student in the graduating class who performed meritorius medical research while an undergraduate medical student. Dr. Norins did research on transient respiratory response to carbon dioxide inhalation.

Winner of the James P. Simonds award of $50 and a certificate for the outstanding junior medical student was Edwin L. Cohen, of Toledo, Ohio. The award was established this year by Phi Chi fraternity in honor of Dr. James P. Simonds, emeritus professor and chairman of the department of pathology at the medical school. The winner is selected for clinical achievement and promise as shown in the first study of clinical medicine in hospitals during the junior year.

Donald M. Hopkins, of Walnut, Ill., received $100 and a certificate as winner of the George J. Dennis Phi Rho Sigma award for the highest scholastic average in studies during his first three years of medical school

A certificate of recognition was given to Phi Delta Epsilon as the medical fraternity maintaining the highest scholastic average for the year and Dr. Melvin P. Firestone, of Jersey City, N. J., received a $50 bond as the student in the fraternity who contributed most toward winning the award.

Edward H. Cornell, Park Ridge, was the recipient of the $50 Leslie B. Arey award, given to the freshman student with the highest grade in anatomy studies. Phi Beta Pi fraternity established the award in honor of Dr. Leslie B. Arey, professor and chairman of the department of anatomy. The fraternity also gives $100 to the Archibald Church Library each year for the purchase of books for the Leslie B. Arey collection.

Names of the winners will be inscribed on plaques which hang in the Archibald Church Library of the medical school.

Society News.—The Chicago Neurological Society was addressed, October 18, by Nicholas Wetzel, on "Fractional Pneumoencephalography"; Ruth Geiger, "Studies on Adult Brain Cortex in Tissue Culture;" and Joseph P. Evans and Adolph Rosenauer, "Studies in Intracranial Pressure."

Retirement at Illinois.—Seven members of the faculty of the University of Illinois College of Medicine retired September 1, with the rank of emeritus. They are: Dr. F. E. Senear, head of the department of dermatology; Dr. W. H. Theobald, department of otolaryngology; Dr. B. H. Hilkevitch, department of medicine (Rush); Dr. E. J. Berkheiser, department of orthopedics; Dr. Harry R. Hoffman, department of psychiatry (Rush); Dr. A. Bambarger, department of surgery; and Dr. H. L. Baker, department of surgery (Rush).

Golden Apple Awards.—The Medical Student Council of the University of Illinois College of Medicine recently presented "Golden Apple Awards" which designate the Raymond B. Allen instructorship awards at the University of Illinois

College of Medicine. Dr. Richard J. Winzler, head of biological chemistry, received a "Golden Apple" key from the freshman class and Dr. William V. Whitehorn, professor of physiology, from the sophomore class. Recipients of keys from the junior class were Dr. Nicholas J. Cotsonas, assistant professor of medicine and Dr. Oglesby Paul, clinical associate professor of medicine. Senior class keys went to Dr. Carl J. Marienfeld, clinical associate professor of pediatrics and Dr. John T. Reynolds, clinical associate professor of surgery.

The awards honor excellency in instruction rendered by the faculty. The freshman and sophomore classes each select one faculty member and the junior and senior groups give two awards. One to a clinical and one to a didactic instructor. Names of the award winners are engraved on the Raymond B. Allen instructorship award plaque in the Illini Union.

University News.—Drs. Lester H. Rudy and Thomas T. Tourlentes have recently joined the faculty of the University of Illinois College of Medicine as clinical assistant professors of psychiatry.

Dr. Alexander Plans New Post.—Dr. Franz Alexander, professor of psychiatry at the University of Illinois College of Medicine since 1943, plans to become head of the department of psychiatry of Mount Sinai Hospital, Los Angeles, in the fall of 1956. Dr. Alexander has been on a leave of absence from Illinois, but will return to his position there next January.

Diabetes Week.—The Chicago Diabetes Association, in co-operation with medical and civic groups, sponsored a Diabetes Detection Drive as part of the annual Diabetes Week observance, November 13-19. The objective was to bring as many as possible undetected diabetics under the care of their physicians before the condition reached a stage where it may lead to serious complications. Free tests were available to those who wished them.

Dr. R. Lincoln Kesler and Dr. Carl A. Hedberg, co-chairmen of the Committee on Detection and Education, were in charge of the program for the Chicago Diabetes Association. Dr. Kesler is clinical assistant professor of medicine, University of Illinois College of Medicine, and Doctor Hedberg is Chief of the Department of Medicine, Augustana Hospital. Serving with them as committee members are: Dr. Henry T. Ricketts, President of the American Diabetes Association, Dr. Arthur R. Colwell, President, Chicago Society of Internal Medicine; and Dr. Ford K. Hick, professor of medicine, University of Illinois College of Medicine.

Chicago's First Conference on Retirement.—The first conference ever to be held in Chicago on general retirement problems of industry will take place Wednesday, November 30, from 9:00 a.m. till 4:00 p.m. in the Grand Ballroom of the Sherman Hotel under the joint sponsorship of the Chicago Heart Association and the Chicago Association of Commerce and Industry.

Heading a list of distinguished speakers is Dr. Irving S. Wright, Past President of the American Heart Association, Professor of Clinical Medicine, Cornell University Medical College, and one of America's leading heart specialists. Dr. Wright will address the luncheon meeting on the much debated subject, "Chronological Age vs. Biological Age as a Basis for Retirement."

The other luncheon speaker on the subject of when a man should be retired will be Meyer Kestnbaum, President of Hart, Schaffner & Marx.

The theme for the morning session of the conference is: "Postponing Premature Retirement." In the afternoon the subject to be discussed is: "Approaches to Retirement."

LAKE

Society News.—Dr. Forrest G. Shufflebarger addressed the Lake County Medical Society in Waukegan, October 11, at a dinner meeting in the Elks Club. His subject was "Alcoholism."

New Executive Secretary.—Mr. Howard N. Schulz has been employed as executive secretary of the Lake County Medical Society. He will serve on a part time basis. In the future all communications for the Lake County Medical Society should be mailed to P. O. Box 148, Gurnee, Illinois. The new phone number of the society is Delta 6-0025. Mr. Schulz may be reached at this number in the evenings after 5:30 p.m. and on weekends. According to the Bulletin of the Lake County Medical Society, there will be someone available to take messages at this number at almost all other hours.

Personal.—Dr. William E. Cape announces his association in the practice of internal medicine with Dr. John L. Ward in Lake Bluff.

PEORIA

Society News.—Dr. Paul D. Crimm, Sidney, Ohio, addressed the Peoria Medical Society at the Peoria Municipal Tuberculosis Sanitarium, October 7, his subject was "Organizational, Medical and Financial Problems Involved in the Control of Tuberculosis." Dr. Harold Himwich, Galesburg, addressed the society recently on "Clinical Evaluation and Basic Studies of the New Psychopharmacological Agent."

ST. CLAIR

Personal.—Dr. Harry Phillips, East St. Louis, was named the first vice-president of the American Academy of Psychosomatic Medicine.

Society News.—Dr. Grey Jones, assistant clinical professor of obstetrics and gynecology, St. Louis University School of Medicine, addressed the St. Clair County Medical Society at St. Henry's school auditorium, Belleville, October 6. His subject was "Retrodisplacement of the Uterus."

SANGAMON

Society News.—"How To Get Along With Newspapermen" was discussed by Mr. Alden C. Waite, editor and publisher of the Illinois State Journal, before the Sangamon County Medical Society, October 6, at a meeting in the Elks Club. "Present Problems Facing Medical Education" was discussed by Dr. James W. Colbert, Jr., Dean of St. Louis University School of Medicine, St. Louis.

GENERAL

Eye, Ear, Nose, and Throat Meeting.—The tenth annual meeting of the Central Illinois Society of Ophthalmology and Otolaryngology was held in Bloomington, October 6-8, with Dr. Watson W. Gailey, Bloomington, in charge. He was assisted by Dr. Stuart Broadwell, Springfield. Officers of the society are Drs. Perry Duncan, Springfield, president; Edward Albers, Champaign, vice president; Walter Owens, Peoria, president-elect; and Clarence Fleischli, Springfield, secretary-treasurer. Among the outstanding speakers at the October meeting were: Drs. Henry Williams, Rochester, Minnesota; Ramon Castroviejo, New York City; H. M. Goodyear, Cincinnati, Ohio; Forrest Pinkerton, Honolulu, Hawaii; Arnold Pillat, Vienna, Austria; Howard House, Los Angeles, California; and Harold Henkes, Rotterdam, The Netherlands.

Postgraduate Conferences.—On October 20, a Postgraduate Conference was held at Vandalia under the auspices of the Postgraduate Education Committee of the Illinois State Medical Society, in co-operation with the staff of the Veterans Administration Hospital at Hines and with the Fayette County Medical Society acting as host. Speakers included: Drs. Robert Poske, "Rheumatic Fever: Diagnosis, Prophylaxis, and Treatment"; Robert F. Penn, "Management and Complications of Eye Injuries"; Clifford Smith, "Treatment of Hepatic Failure"; William S. Walsh, "Diagnosis and Management of Tumor Masses of the Neck"; Bernard Edidin, "Ulcerative Colitis: Differential Diagnosis and Treatment;" and James F. Kurtz, "Intramedullary Fixation of Fractures of the Shaft of the Femur." Dr. Stanley W. Moore, Vandalia, served as moderator during the discussion periods. The evening address was given by Dr. W. J. Gillesby on "Surgical Diseases of the Pancreas."

On October 27, the Whiteside County Medical in Sterling under the auspices of the Postgraduate Education Committee in co-operation with the faculty of the Stritch School of Medicine of Loyola University. Dr. George F. O'Brien was moderator at the session on "Treatment of Congestive Heart Failure." Speakers were: Drs. Peter J. Talso, John J. O'Brien, and John B. Hoesley. Dr. Dexter Nelson, Princeton, was the Discussion Leader. Dr. Harry A. Oberhelman was moderator for the subject "Acute Surgical Abdomen". Speakers were: Drs. John B. Condon, Anthony C. Guzauskas, and James A. Rooney. Dr. Lester S. Reavley, Sterling, was the Discussion Leader. Other subjects were: "Ovarian Carcinoma" by Dr. John H. Isaacs and "Management of Uterine Myoma" by Dr. Chester J. Gajewski. The discussion leaders were Drs. C. Paul White, Kewanee, and M. David Burnstine, Sterling, respectively. In the evening Dr. Raymond J. Dern spoke on "Experiences in Medical Research at Stateville."

"Your Doctor Speaks" on FM Station WFJL.—The following physicians have recently appeared in transcribed broadcasts on FM Station WFJL, Thursday evenings, at 7:45 p.m. The series, entitled "Your Doctor Speaks", is presented by the **Educational Committee** of the **Illinois State Medical Society:**

Patrick Riley, associate in radiology, Northwestern University Medical School, September 29, on Role of the Radiologist in Medical Practice.

Walter W. Dalitsch, co-director of the Cleft Lip and Palate Institute of Northwestern University, Modern Care for the Cleft Lip and Palate Child.

Harry LeVeen, associate professor of surgery, Chicago Medical School, October 13, on Burns.

Lectures Arranged Through the Educational Committee of the Illinois State Medical Society:

Joel S. Handler, clinical assistant professor of psychiatry, University of Illinois College of Medicine, Maine Township Adult Evening School in Park Ridge, October 10, on Mental Health.

J. Henry Heinen, Jr., Young Women's Christian Association, November 1, on Care of the Feet from an Orthopedic Standpoint.

Robert S. Mendelsohn, Illinois Federation of Women's Clubs, November 2, in Chicago, on Immunization Problems with Special Emphasis on Polio Vaccination.

Lectures Arranged Through the Scientific Service Committee of the Illinois State Medical Society:

Orin H. Stuteville, professor of maxillo-facial surgery, Northwestern University Dental School, and lecturer in surgery, Northwestern University Medical School, October 28, on Oral Surgery.

William H. Requarth, Decatur, Englewood Branch of the Chicago Medical Society, November 1, on Injuries of the Hand.

Karl D. Venters, Centralia, Wayne County Medical Society at Fairfield Memorial Hospital, Fairfield, November 17, on Fluid Balance.

Armand J. Mauzey, clinical assistant professor of obstetrics and gynecology, Univerity of Illinois College of Medicine, Lee-Whiteside County Medical Societies at the Plum Hollow Country Club, Dixon, November 17, on Office Gynecology.

Charles J. Smith, assistant clinical professor in obstetrics and gynecology, Stritch School of Medicine of Loyola University, Englewood Branch of the Chicago Medical Society, December 6, on Dangerous Placenta.

John W. Payne, LaGrange, instructor in obstet-

rics and gynecology, University of Illinois College of Medicine, Knox County Medical Society, December 15, in Galesburg, on Hormonal Disorders in Pregnancy.

Carlo Scuderi, clinical associate professor of surgery, University of Illinois College of Medicine, Stock Yards Branch, Chicago Medical Society, December 16, on Diagnosis and Management of Common Shoulder Injuries.

DEATHS

William Reuben Albus*, Chicago, who graduated at Rush Medical College in 1933, died September 10, aged 61, of a cerebral vascular accident. He was formerly a member of the professional field staff of the Council on Medical Education and Hospitals of the American Medical Association.

Frank Parkinson Auld, Shelbyville, who graduated at Barnes Medical College in 1903, died July 16, aged 79. He was at one time district health superintendent of the Illinois State Department of Health.

Armin L. Blaufuss*, Geneva, who graduated at the University of Illinois College of Medicine in 1936, died October 4, aged 52. He was formerly resident physician at Kankakee State Hospital and Geneva Community Hospital.

Harold Curtis Bowser*, Urbana, formerly of Sidney, who graduated at Syracuse University College of Medicine in 1938, died August 29, aged 41.

Joel LeRoy Deuterman*, Elgin, who graduated at the University of Virginia Department of Medicine in 1930, died August 7, aged 53, of malignant tumor of the pituitary gland. He was a member of the staffs of the Sherman and St. Joseph Hospitals.

Roscoe P. Donovan, Hoopeston, who graduated at St. Louis College of Physicians and Surgeons in 1906, died June 25, aged 70.

Frederick W. Fitz*, Chicago, who graduated at Northwestern University Medical School in 1934, died October 8, aged 53. He was associate professor of medicine at Northwestern and the Chicago Tribune's first medical counselor.

Henry B. Gilborne, Herscher, who graduated at Chicago Homeopathic Medical College in 1901, died September 5, aged 79. He had practiced medicine in Kankakee County for twenty years.

Horatio Norman Greaves, Champaign, who graduated at Rush Medical College in 1907, died July 31, aged 74. He was a member of the staff of the Burnham City Hospital.

Blair Kelly*, Ferris, who graduated at Keokuk Medical College, College of Physicians and Surgeons, in 1902, died August 25, aged 79. He had practiced medicine more than fifty years and was a past president of the Hancock County Medical Society.

Joseph Abraham Khamis, Chicago, who graduated at the Chicago College of Medicine and Surgery in 1910, died July 2, aged 77.

Adalbert Klaptoz*, Chicago, who graduated at Medizinische Fakultät der Universität, Vienna, Austria, in 1910, was frozen to death in a blizzard near Linz, Austria, while mountain climbing, August 8, aged 69.

Joseph S. Lambert, retired, Chicago, who graduated at Northwestern University Medical School in 1893, died August 8, aged 88, of chronic myocarditis.

Abraham Levinson*, Chicago, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1911, died September 17, aged 67. He was professor of pediatrics at Northwestern University Medical School, chief of staff of Cook County's Children's Hospital, and senior attending physician at Michael Reese and Mount Sinai Hospitals.

Ethelbert A. Lutton*, Chicago, who graduated at Northwestern University Medical School in 1918, died October 1, aged 62. He was on the staff of South Shore Hospital and a member of the International College of Surgeons.

Nathan David Leviton, Chicago, who graduated at Northwestern University Medical School in 1911, died August 16, aged 70.

Andrew R. McCradie*, Chicago, who graduated at the University of Illinois College of Medicine in 1920, died September 8, aged 61.

Philip R. Noe*, Centralia, who graduated at Milwaukee Medical College in 1912, died recently, aged 71.

James William Parker, Peoria, who graduated at the State University of Iowa College of Homeopathic Medicine in 1888, died April 4, aged 87, of cerebral hemorrhage and arteriosclerosis.

Carl Melancton Peterson*, Chicago, who graduated at the University of Minnesota Medical School in 1927, died as a result of injuries sustained in an airplane crash, September 27, aged 55. Since 1938 he had served as Secretary of the Council on Industrial Health of the American Medical Association.

Charles H. Pike, Evanston, who graduated at the University of Pennsylvania School of Medicine in 1912, died October 7, aged 69.

Harry Rosenberg*, formerly of Chicago, who graduated at the Chicago Medical School in 1929, died in Los Angeles where he had moved a month ago, September 18, aged 59. He was formerly a member of the staff of the Edgewater Hospital.

Jacob Samuel*, Chicago, who graduated at Northwestern University Medical School in 1920, died September 19, aged 59. He was a member of the staff of the South Chicago Community Hospital.

Richard Charles Shurtz*, Champaign, who gradu-

*Indicates member of the Illinois State Medical Society.

ated at the University of Illinois College of Medicine in 1927, died July 29, aged 60, of acute bacterial endocarditis. He was at one time coroner of Champaign County.

John C. Souders, Sr.*, Rock Island, who graduated at State University of Iowa College of Medicine in 1904, died August 23, aged 83.

Samuel Isaac Weiner*, Chicago, who graduated at the University of Illinois College of Medicine in 1925, died July 9, aged 58. He was a member of the staff of Mount Sinai Hospital.

Gilford N. Welch*, Centralia, who graduated at the National University of Arts and Sciences Medical Department, St. Louis, in 1914, died recently, aged 65.

*Indicates member of the Illinois State Medical Society.

‹‹‹ ›››

The patient with nephritis

Patients with chronic latent nephritis are urged to live as normal lives as possible. One should not superimpose upon the chronic renal disease, usually asymptomatic within itself, functional symptoms induced by frequent examinations and restriction of activity. The life span of such patients is often many years. They should be encouraged to complete their education and to make their due contributions to society. Because respiratory infections are often associated with exacerbations of renal inflammation, nephritic patients should guard themselves against excessive fatigue and inclement weather. Infections should be treated promptly with antibiotic agents if there is any suspicion that they are due to susceptible bacteria. *Hall S. Tacket, M.D. Management of Chronic Renal Disease. J. Tennessee M.A. August, 1955.*

One fact which must be acknowledged and is of practical importance is that over the country the annual number of newly reported cases of tuberculosis has declined very little. In fact, the number increased from 1940 until 1948 and, while it has gone down for the past four years, in 1952 it was still slightly higher than in 1940, although the case rate has gone down since it is affected also by the increasing population. Even though many of these cases do not require hospitalization, all should be investigated, their clinical status determined, their familial contacts studied, and other appropriate control measures taken where indicated. Thus, there has been no decrease in the effort required of health departments and voluntary agencies, and no reduction in personnel or funds should be contemplated. In fact, greater effort is demanded if tuberculosis is to be eradicated, and no lesser goal should satisfy us. Philip E. Sartwell, M.D., Nat. Tuberc. A. Tr., May, 1954.

More palatable and
better tolerated
than either
potassium iodide
or Lugol's Solution . . .

AMEND'S SOLUTION permits safe, adequate iodine therapy without fear of iodism.

Whenever oral iodine
is indicated, prescribe
10 to 20 drops of
AMEND'S SOLUTION
t.i.d., a.c., in a full glass
of water. Available in
2 oz. bottles.

AMEND'S SOLUTION
(protein-buffered iodine)

Additional information available on request.

Thos. Leeming & Co. Inc.
155 East 44th Street, New York 17, N.Y.

BOOK REVIEWS

ATLAS OF HAEMATOLOGY by Sandoz LTD., Basle. Published by Fronbenius Ltd., Basle, Switzerland — Copyright 1952 — Price $7.00.

This book is more than an atlas. It contains a very complete text logically arranged. Each blood element is taken up separately and a detailed description of its origin, development and eventual disintegration ably delineated. Clear descriptions of both its normal and pathological course is described. Accompanying each description of a cellular element are excellent color plates. Presented also are descriptions and technics for all the various stains and laboratory procedures used in hematology. Of particular interest is a section on the "Investigation of the Therapeutic Action of Ferrous Iron in Iron-deficiency Anemia".

This book contains 91 pages and has an excellent bibliography and index. The pages are large 8″x11″ sheets and are placed in a strong looseleaf binder. Because there is permitted ample room in the binder the reader may add his favorite color plates which he has been saving through the years to the text and have a readily available and safe repository for his treasures.

GERIATRIC MEDICINE By Edward J. Stieglitz, M.D., Medical Care of Later Maturity Third Edition. 205 Figures. Published by J. B. Lippincott Company.
Copyright 1954 Price $15.00

This is the third edition of this text covering a subject matter which is growing of increasing importance in every field of medicine. The editor has skillfully blended the talents of almost fifty outstanding specialists. Such respected authorities as Auton J. Carlson, Walter Priest, and Herbert Rattner and others have crystalized the particular problems of aging in their respective specialties to contribute toward an intelligent and warm mosaic of the entire field of geriatrics. Much attention has been paid to the normal senescence with its emphasis on prevention of complications and avoidance of future pathology.

The keynote of this text is the dynamic maintenance of our geriatric patient in a usefull healthy and happy group in their twilight years.

J.W.P.

PERIPHERAL VASCULAR DISEASES by Edgar V. Allen, B.S., M.A., M.D., M.S. in Medicine, F.A.C.P. Nelson W. Barker, B.A., M.D., M.S. in Medicine F.A.C.P. Edgar A. Hines, Jr., B.S., M.A., M.D., M.S. in Medicine, F.A.C.P. With Associates in the Mayo Clinic and Mayo Foundation. 316 Illustrations. 7 in Color. Published by W. B. Saunders Company, Philadelphia, London, 1955.
Copyright 1955 Price $13.00

This is a most scholarly and comprehensive text on the peripheral vascular diseases more applicable to the specialist in the field but still of great value to students and men engaged in general practice. The book is introduced by a chapter on the accurate definition of terms which greatly clarifies the complexities of this subject which overlaps so many fields in medicine and surgery. The index is adequate and the biblio-

(*Continued on page 76*)

VAGINAL TRICHOMONIASIS TRAVELS FROM MR. TO MRS.

It often happens that the physician's time and skill in clearing up vaginal trichomoniasis are wasted because the husband will re-infect the wife. Fortunately, there is a method of circumventing this endless cycle of re-infection.

Husband often the carrier. "Approximately 39 to 47 per cent of resistant cases are reinfections from the sexual partner."[1] Whittington reports infestation in the male in 27 per cent[2] and Freed in 28.5 per cent.[3] A study of all foci of infection, such as urethra, prostate, seminal vesicles, bladder, kidneys, pelvis and preputial sac, would probably reveal even higher incidence in the male.

Danger without signals. Trichomonads in the male rarely produce symptoms to signal their presence.[4]

Prevent re-infection. Karnaky recommends in recurrent cases that the husband wear a condom during coitus for four to nine months. By the end of this time the trichomonads will usually die out.[5] Davis states: "Use of a sheath by the husband has long been advised during the period a woman is under treatment and should be used permanently if he carries the infection."[6]

Prescribe quality condoms. To eliminate trichomonads "once and for all," take specific measures to win cooperation of the husband. In prescribing a condom, be selective as to quality and take advantage of Schmid product improvements.



When there is anxiety that the condom might dull sensation, the answer is to prescribe XXXX (FOUREX)® skins. Made from the cecum of the lamb, they feel like the patient's own skin, are pre-moistened and do not retard sensory effect. If cost is a consideration, prescribe RAMSES,® a transparent, tissue-thin, yet strong condom of natural gum rubber. SHEIK,® also a natural gum rubber condom, is even more reasonable in price.

Isn't it true that any husband, any wife, in your practice would prefer to hand the druggist your *prescription* for a condom, rather than to ask for it "in public"? This is another instance of diplomacy in medicine to prevent an embarrassing situation. To assure finest quality and earn appreciation for your thoughtfulness, prescribe XXXX (FOUREX), RAMSES or SHEIK condoms by name. Prescribe Schmid protection for as long as *four* to *nine* months after the wife's infestation has cleared. The protection Schmid condoms afford is the very foundation of re-infection control.

References: 1. Karnaky, K. J.: Urol & Cutan. Rev. *48*:812 (Nov.) 1938. 2. Whittington, M. J.: J. Obst. & Gynaec. Brit. Emp. *58*:614 (Aug.) 1951. 3. Freed, L. F.: South African M. J. (March 27) 1948, as abstracted in Urol. & Cutan. Rev. *52*:489 (Aug.) 1948. 4. Bernstine, J. B., and Rakoff, A. E.: Vaginal Infections, Infestations, and Discharges, New York, The Blakiston Co., 1953. 5. Karnaky, K. J.: J.A.M.A. *155*:876 (June 26) 1954. 6. Davis, C. H.: West. J. Surg. *63*:53 (Feb.) 1955.

JULIUS SCHMID, INC., *prophylactics division*
423 West 55th Street, New York 19, N. Y.

XXXX (FOUREX), RAMSES and SHEIK are registered trade-marks of Julius Schmid, Inc.

BOOK REVIEWS (Continued)

graphy at the close of each chapter is rich and discriminating. The illustrations live drawings, photographs and color plates are clear and rewarding. Delightful features are photographs and short biographies of outstanding contributors to the field of peripheral vascular diseases such as: Raymond, Matas and Lewis scattered throughout the text.

It is difficult to find fault with so masterful a presentation of this complex subject.

J.W.P.

BOOKS RECEIVED

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

Cough Syncope. By Vincent J. Derbes, M. D., Professor of Medicine and Director of the Division of Allergy and Dermatology, Tulane, University of Louisiana State University School of Medicine. Foreword by Roscoe Pullen, M. D. $4.75. Charles C. Thomas, Publisher, 301-327 East Lawrence Avenue, Springfield, Illinois.

Handbook of Pediatrics. By Henry K. Silver, M. D., Associate Professor of Pediatrics, Yale University School of Medicine, C. Henry Kempe, M. D. Asst. Professor of Pediatrics, University of California School of Medicine, Henry B. Bruyn, M. D., Asst. Professor of Pediatrics and Medicine, University of California, School of Medicine, San Francisco., Assistant Clinical Professor of Pediatrics, Stanford University Medical School.

Proceedings of the Third Medical Conference of Muscular Dystrophy, Association of American, Inc. 39 Broadway New York, New York. October 8 and 9, 1954.

Henry Ford Hospital International Symposium on Cardiovascular Surgery. Studies in Physiology, Diagnosis and Techniques. Proceedings of the Symposium held at Henry Ford Hospital, Detroit, Michigan; March, 1955. Edited by Contad R. Lam, M.D., Surgeon-in-charge, Division of Thoracic Surgery, Henry Ford Hospital. Pages: 543; illustrated. Publication Date: September 13, 1955. Price $12.75. W. B. Saunders Company, Philadelphia and London.

Cardiac Diagnosis—A Physiologic Approach. Au thor: Robert F. Rushmer, M.D., Associate Professor of Physiology and Biophysics, University of Washington Medical School. Pages: 447; Illustrated. Publication date: September 22, 1955. Price $11.50.

(*Continued on page* 80)

Lederle

FOLBESYN*

Vitamins *Lederle*

A well-balanced, high-potency vitamin formula containing B-Complex and C

Folbesyn provides B-Complex factors (including folic acid and B_{12}) and ascorbic acid in a well balanced formula. It does not contain excessive amounts of any one factor.

Folbesyn Parenteral may be administered intramuscularly, or it may be added to various hospital intravenous solutions. It is useful for preoperative and postoperative treatment and during convalescence.

Dosage: 2 cc. daily. Each 2 cc. provides:

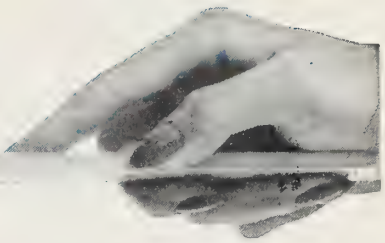
Thiamine HCl (B_1)	10 mg.
Sodium Pantothenate	10 mg.
Niacinamide	50 mg.
Ribloflavin (B_2)	10 mg.
Pyridoxine HCl (B_6)	5 mg.
Ascorbic Acid (C)	300 mg.
Vitamin B_{12}	15 micrograms
Folic Acid	3 mg.

Folbeysn is also available in tablet form, ideal for supplementing the parenteral dose.

LEDERLE LABORATORIES DIVISION *American Cyanamid company* Pearl River, New York

*Reg. U.S. Pat. Off.

Lysine plus vitamins for better appetite, faster growth—





New!

INCREMIN*

Lysine-Vitamin Drops

Here, at last, is an effective remedy for poor appetite and slow growth in infants and children! Lysine, an amino acid, has shown remarkable results in stimulating the rate of growth of infants, particularly those with poor appetites. Vitamins B_1, B_6, and B_{12} have long been recognized as appetite stimulants. INCREMIN combines these four essential nutrients.

Cherry-flavored INCREMIN Drops can be added to milk, milk formula, or other liquid. An unbreakable "squeeze" bottle facilitates accurate, easy dispensing for the parent.



In 15 cc. polyethylene dropper bottle.
Dosage: 0.5 to 1 cc. (10-20 drops) daily.
Each cc. (20 drops) contains:

l-Lysine HCl	300 mg.
Vitamin B_{12}	25 mcgm.
Thiamine HCl (B_1)	10 mg.
Pyridoxine HCl (B_6)	5 mg.
Alcohol	1%

GERIATRIC USES, TOO! INCREMIN may also be prescribed as an appetite stimulant for the elderly patient.

LEDERLE LABORATORIES DIVISION
AMERICAN Cyanamid COMPANY
PEARL RIVER, NEW YORK

Lederle

*REG. U.S. PAT. OFF.

BOOKS RECEIVED (Continued)

W. B. Saunders Company, Philadelphia and London.

BASIC SURGICAL SKILLS. A Manual with Appropriate Exercises. Author: Robert Tauber, M.D., F.A.C.S., Assistant Professor of Gynecology and Obstetrics, Graduate School of Medicine, University of Pennsylvania. Pages: 75; Illustrated. Publication date: September 26, 1955. Price $3.75. W. B. Saunders Company, Philadelphia and London.

OFFICE PROCEDURES: Author: Paul Williamson, M.D. Pages: 412; Illustrated. Publication Date: August 18, 1955; Price: $12.50. W. B. Saunders Company, Philadelphia and London.

CANCER CELLS. Author: E. V. Cowdry, Director, Wernse Cancer Research Laboratory, Washington University, St. Louis. Pages: 677. Illustrations: 137 figures. Publication Date: September 1, 1955. Price $16.00. W. B. Saunders Company, Philadelphia and London.

TEXTBOOK OF ENDOCRINOLOGY. Edited by Robert H. Williams, M.D., Executive Officer and Professor of Medicine, University of Washington Medical School, Seattle. Contributors: William H. Daughaday; Peter H. Forsham; Henry B. Friedgood; John Edger Howard; Edward C. Reifenstein, Jr.; William W. Scott; George Van S. Smith; George W. Thorn; Lawson Wilkins; Robert H. Williams. Edition: Second. Pages: 776. Illustrations: 175 figures. Publication Date: August 31, 1955. Price: $13.00. W. G. Saunders Company, Philadelphia and London.

SPLENIN A IN RHEUMATIC FEVER. The Testing of Splenin A as an Anti-inflammatory Agent; By Alvin F. Coburn, M.D., Lucile V. Moore, M.D., Judith Wood, M.D., and Mary Roberts, R.N., from the Rheumatic Fever Research Institute, Northwestern University Medical School, Chicago, Illinois. Charles C. Thomas, Publisher, Springfield, Illinois. Price $3.75.

THE EXPRESSION OF THE EMOTIONS IN MAN AND ANIMALS. By Charles Darwin, M.A., F.R.S., Etc. With Photographic and other Illustrations. With a Preface by Margaret Mead. Philosophical Library, New York. Price $6.00.

‹ ›

Don't be misled into believing that somehow the world owes you a living. The boy who believes that his parents, or the government, or anyone else owes him his livelihood and that he can collect it without labor, will wake up one day and find himself working for another boy who did not have that belief and, therefore earned the right to have others work for him.—*David Sarnoff*



surgery
pediatrics
convalescence
ob - gyn
geriatrics

LIVITAMIN® with IRON
each fluidounce contains:

Iron peptonized..... 420 mg.
(Equiv. in elemental iron to 70 mg.)
Manganese citrate, soluble..... 158 mg.
Thiamine hydrochloride..... 10 mg.
Riboflavin..... 10 mg.
Vitamin B_{12} (crystalline) ..... 20 mcg.
Niacinamide..... 50 mg.
Pyridoxine hydrochloride..... 1 mg.
Pantothenic acid ..... 5 mg.
Liver fraction 1..... 2 Gm.
Rice bran extract..... 1 Gm.
Inositol ..... 30 mg.
Choline ..... 60 mg.

. . . the reconstructive iron tonic of wide application . . .

LIVITAMIN®

WITH IRON

In debilitation, syndrome therapy instead of symptom treatment is required. Livitamin (Massengill) provides comprehensive therapy and adequate nutritional support. The appetite improves, as does the blood picture . . . improved anabolism and better digestion produce a significant syndrome reversal.

LIVITAMIN® CAPSULES with INTRINSIC FACTOR
each capsule contains:

Desiccated liver..... 450 mg.
Ferrous sulfate..... 130 mg.
(Equiv. to 25 mg. of elemental iron)
Thiamine hydrochloride..... 3 mg.
Riboflavin..... 3 mg.
Niacinamide..... 10 mg.
Vitamin B_{12} ..... 5 mcg.
Pyridoxine hydrochloride..... 0.5 mg.
Calcium pantothenate..... 2 mg.
Folic acid..... 1 mg.
Intrinsic factor USP..... 1/6 Unit

. . . in pernicious anemia and geriatrics . . .

LIVITAMIN®

CAPSULES WITH INTRINSIC FACTOR

Intrinsic factor is essential to provide full utilization of antianemic and nutritional factors in P. A. and many Geriatric patients. Livitamin Capsules with Intrinsic Factor (Massengill) contain intrinsic factor, U.S.P., iron and the B-complex vitamins. This integrated medication provides an optimal response in these difficult patients.

THE S. E. MASSENGILL COMPANY
BRISTOL, TENNESSEE

The month in Washington

Washington, D.C.—Within a few months there will be under way the first comprehensive survey ever to be made of the nation's mental health problems. The study will attempt to measure the extent of mental illness, to judge the progress and lack of progress in research, and to estimate the additional hospitals and clinics and trained personnel needed before a start can be made toward a solution.

A newly-formed Joint Commission on Mental Illness and Health already has begun preliminary work on the survey. The all-out effort will be initiated—possibly before the first of the year—after the Commission has received the formal approval of the National Mental Health Advisory Council of U.S. Public Health Service and the Surgeon General. Once this endorsement has been given, $250,000 in U.S. funds will be available to help with the first year's operations. Another million dollars is to be supplied over the following two years.

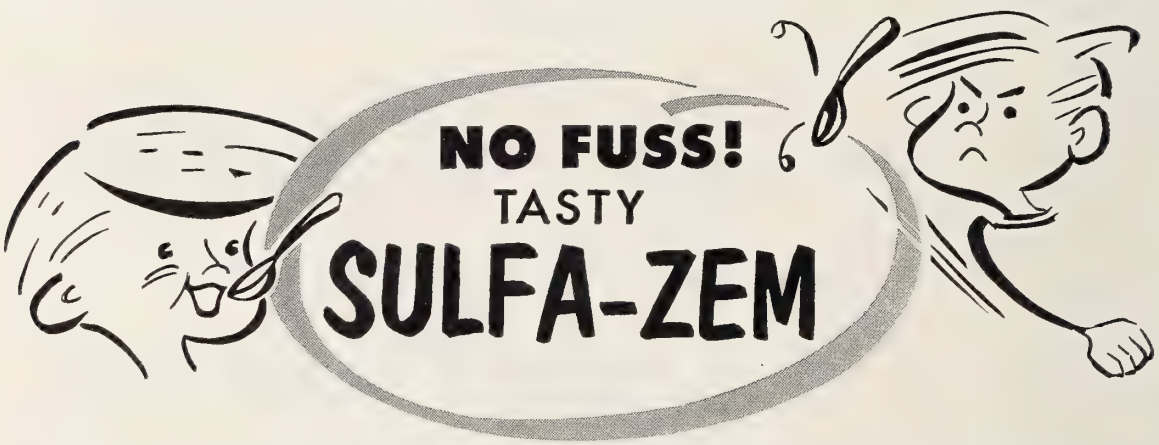
Originally, the Joint Commission was formed by the American Medical Association's Council on Mental Health and the American Psychiatric Association. Later other associations joined in, including the American Association of Psychiatric Social Workers, the American Hospital Association, the American Nurses Association, the National League of Nursing, the American Psychological Association, and the National Education Association.

A nationwide survey has been the objective of these associations for more than a year. Substance was added to the idea this year when Congress approved the $1,250,000 fund, to be used over three years, for a comprehensive study. The law specifies that the investigation be conducted by nongovernmental bodies; to fully qualify, the Joint Commission has been legally incorporated.

At hearings before Congressional committees early this year psychiatrists and others outlined the complex problem they are facing.

The care of mental patients is one of the

(*Continued on page* 84)



Children enjoy taking delicious liquid Sulfa-Zem. Ideal also for those who have difficulty swallowing tablets. The multiple formula offers greatest potency against the greatest number of infections. Sulfa-Zem maintains high blood levels and excellent tissue distribution. Use of only a fractional dosage of 4 different sulfas absolutely minimizes undesirable side effects.

Each teaspoonful (5cc.) contains:

Sulfadiazine	2½ gr. (0.15 Gm.)
Sulfamerazine	2½ gr. (0.15 Gm.)
Sulfamethazine	1½ gr. (0.1 Gm.)
Sodium Sulfacetamide	1 gr. (60 mg.)

16 oz. and 3 oz. bottles.

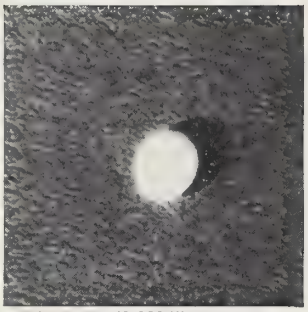
THE ZEMMER CO.
3943 Sennott St. Pittsburgh 13, Pa.

The organisms commonly involved in

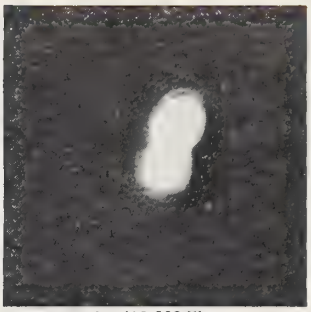
Tracheobronchitis



Str. pyogenes (8,500 X)



Staph. aureus (9,000 X)



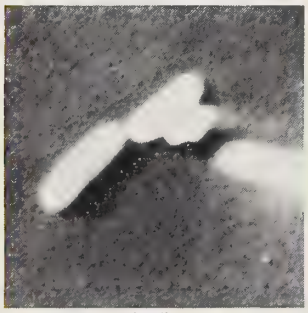
D. pneumoniae (10,000 X)



K. pneumoniae (13,000 X)



H. influenzae (16,000 X)



H. pertussis (7,500 X)

Upjohn

ELECTRON MICROGRAPHS

***All* of them are included in the more than 30 organisms susceptible to broad-spectrum**

PANMYCIN*

HYDROCHLORIDE

100 mg. and 250 mg. capsules • 125 mg. and 250 mg./tsp. oral suspension (PANMYCIN Readimixed)
100 mg./cc. drops • 100 mg./2 cc. injection, intramuscular
100 mg., 250 mg., and 500 mg. vials, intravenous

*TRADEMARK. REG. U.S. PAT. OFF.—THE UPJOHN BRAND OF TETRACYCLINE

WASHINGTON (Continued)

great financial burdens of the states; rate of cure and rehabilitation is so low that institutions are being filled as fast as they can be constructed; half the hospital beds are occupied by mental patients and their care costs more than a billion dollars a year in tax funds.

There are not enough psychiatrists trained to administer state programs or even all the large hospitals; competition for the top men in this field has been compared to the proselyting of football players and coaches.

Many of the leading psychiatrists complain that too much attention is being paid to constructing hospitals and not enough to research, which might develop treatments that would keep many patients out of institutions, and bring about the rehabilitation of hundreds of thousands of others now hospitalized.

In testifying before a House committee early this year, Dr. Leo H. Bartemeier, representing the AMA, argued for federal help in conducting the survey. He told the Committee: "For several years we in the profession of psychiatry have been aware of the critical need for a survey and evaluation of our facilities and programs for the diagnosis, treatment and care of the mentally ill and retarded. While the problems of mental illness appear to grow in almost geometric proportion, we find ourselves without a comprehensive, up-to-date, integrated body of knowledge in spite of the fact that many worthwhile surveys and studies in this field have been made. It is only with such complete knowledge that our present and future direction and programs can be properly planned."

NOTES:

Before it prepares a report on the narcotic problem, the Senate subcommittee will have held hearings in most parts of the country. Many local addiction problems have been described. At the New York hearing, the subcommittee was urged to recommend a system of clinics, where the addict legally could obtain narcotics at reasonable cost, thereby defeating the rackets.

Although states either may take U.S. grants to buy Salk vaccine or the vaccine itself, most of them are taking the money.

Veterans Administration has set up a seventh area medical office in Columbus, Ohio, a move

(*Continued on page* 86)

1950 Cortone® | 1952 Hydrocortone®
1954 'Alflorone' | 1955 'Hydeltra'

DELTRA® tablets

(Prednisone, Merck)

5 mg. - 2.5 mg. - 1 mg. (scored)

the delta-1 analogue of cortisone

Indications:

Rheumatoid arthritis

Bronchial asthma

Inflammatory skin conditions

SHARP & DOHME

Philadelphia 1, Pa.
DIVISION OF MERCK & CO., INC.



Diatussin changes difficult-to-dose children into willing patients. Mothers, too, like *Diatussin* because it's easier to give. Two to four drops do the work of spoonfuls of syrup.

Dropped directly on the tongue or on a spoonful of dessert or cereal, *Diatussin* lessens frequency and severity of cough. Non-narcotic, *Diatussin* preserves the vital cough reflex, avoids sedation and gastro-intestinal disturbances.

tykes don't "take on" when they take...



DIATUSSIN®

non-narcotic cough control

Bischoff DIVISION

Dosage:

Under 5 years...2 to 4 drops three or four times daily. Over 5 years...5 drops three or four times daily.

Formula:	*Diatussin*
Thyme (alcoholic extract) . . .	39%
Drosera (alcoholic extract) . . .	39%
Ethyl alcohol	22%

Supplied in 6-cc. bottles with dropper.

Diatussin Syrup, in 4-oz., pint and gallon bottles, contains in each teaspoonful 2 drops of the extract in an aqueous dextrose vehicle.

AMES COMPANY, INC · ELKHART, INDIANA

64655

WASHINGTON (Continued)

that it believes eventually will provide better service at less cost.

Almost nine million dollars will be spent next year on health work in North, South and Central America by international bodies, such as World Health Organization. One project is the starting in Mexico of a four-year malaria eradication program.

The Navy has set up a program for training Waves as nurses; they will be obligated for a year's active duty for each year of training.

Bureau of Internal Revenue has summarized deductible and nondeductible medical expenses for income tax purposes; the listings combine new interpretations with a clarification of old rulings.

‹ ›

If this world affords true happiness, it is to be found in a home where love and confidence increase with the years, where the necessities of life come without severe strain, where luxuries enter only after their cost has been carefully considered. —*A. Edward Newton*

The elimination of tuberculosis from the midwestern states in the next fifty years

By David T. Smith, M.D., Diseases of the Chest, December, 1954.

The National Tuberculosis Association was founded fifty years ago. At that time the public believed that tuberculosis was inherited and that to plan its control was a utopian dream. The death rate in the death registration area was 200 per 100,000, with the major part of the deaths in infants and young adults. In the northeastern states nearly 100 per cent of the population had a positive tuberculin test by the age of 20. There were only a few thousand beds for patients with tuberculosis in the entire United States. The X-ray technique for finding tuberculosis was undeveloped and case-finding clinics as we know them today were non-existent. There were only two encouraging factors: deaths from tuberculosis had been almost twice as frequent 50 years before and a new organization had dedicated itself to the elimination of this dreadful disease.



It is probable that the death rate from tuberculosis in the midwest was never as high as in the northeast. There the standard of living was higher and the opportunity for infection was less than in the more crowded northeastern states.

By 1920 in the midwest there were enough sanatorium beds to isolate and treat most of the known active cases. However, many cases were missed until the X-ray method had been perfected and larger segments of the population X-rayed.

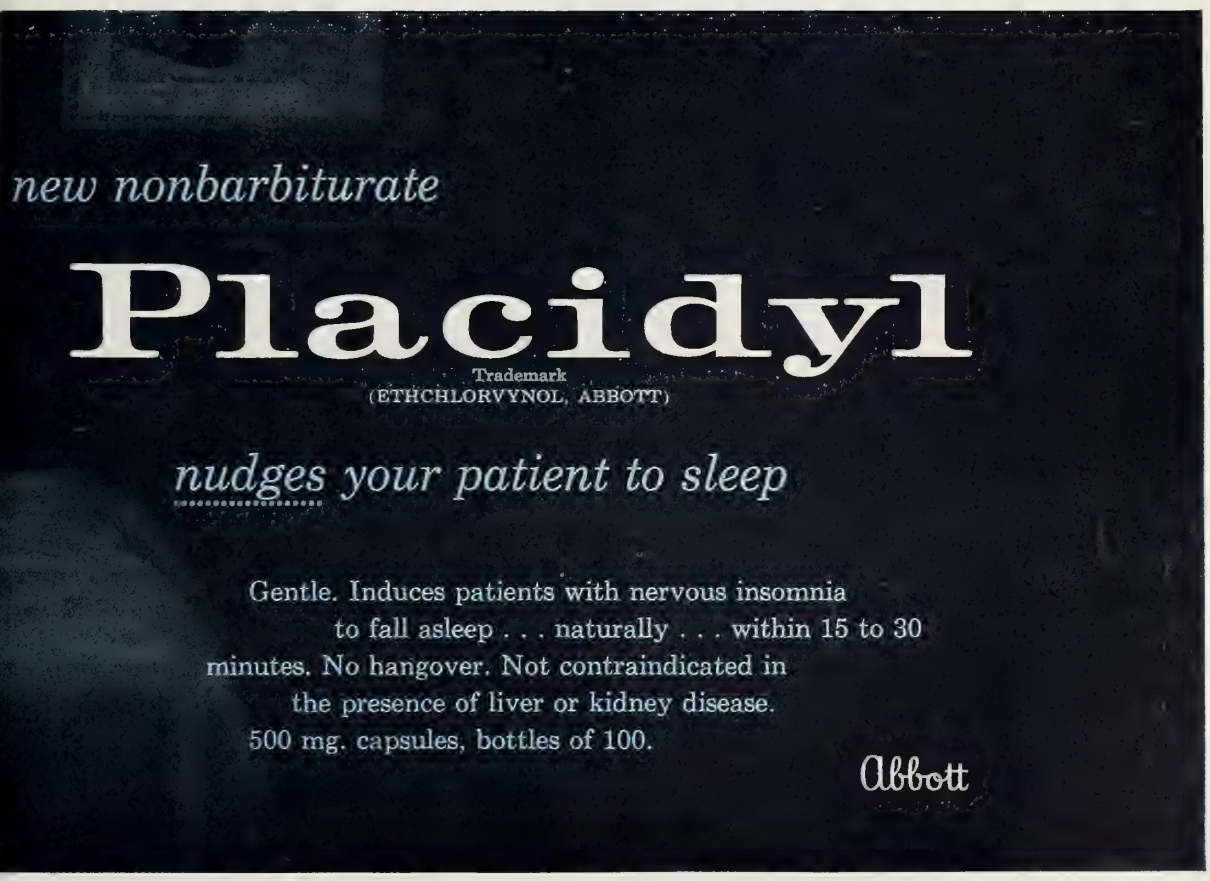
There are no accepted criteria for determining when tuberculosis is under control in an area. It is suggested that tuberculosis be considered under control when the death rate is five or less per 100,000 of the population and five per cent or less of the school population have positive tuberculin tests. Wisconsin is approaching this goal of control; the death rate for 1952 being 6.5 and tuberculin tests in school children in 1950 five per cent positive. The other midwestern states are approaching the status of control.

When tuberculosis is under control then we can begin to plan for its eradication. To consider the crude overall death rate alone is misleading. The age and sex groups which harbor the remaining reservoirs of infection must be known.

The most striking feature of the 1950 figures is the steady rise in the Wisconsin death rate for men from a low of 0.1 at the age of 12 to 61.2 at the age of 85. The chief reservoir of tuberculous infection is now in males over 40 and females over 60 years of age. This is the seed bed from which the next generation will be infected unless all of the active cases are detected, isolated, and treated.

Almost as many new cases are being found now as were being found when the death rate was four times as high. Indeed, one may conclude that the present death rate is an artificial condition brought about by early diagnosis, better medical and surgical treatment, and is not the result of a natural decrease in either the prevalence or severity of tuberculosis. If treatment should continue to improve we might find ourselves in an anomalous situation in which there

(*Continued on page* 88)



TUBERCULOSIS (Continued)

were no deaths but with a continuing heavy load of active cases in our hospitals. The greatest defect in our present methods of control is the lack of specific information in regard to the number, age and sex distribution of individuals who have been infected.

The percentage of positive tuberculin reactors is an indirect measure of the amount of undetected open tuberculosis in the community. A positive tuberculin test pinpoints the individuals in the group in which new active cases will develop. A recent conversion from a negative to a positive tuberculin reaction means that there is an active case among the converter's associates. There is a rough correlation between the percentage of the population with positive tuberculin reactions and the number of clinical cases and the number of deaths from tuberculosis.

In 1950 in Wisconsin there was an average rate of 1.7 deaths per 100,000 for the age group under 20 and 26 per 100,000 for the ages of 50 to 80. The school children in Wisconsin have five per cent positive tuberculin reactors and it is assumed that the older groups have a tuberculin rate of 50 per cent.

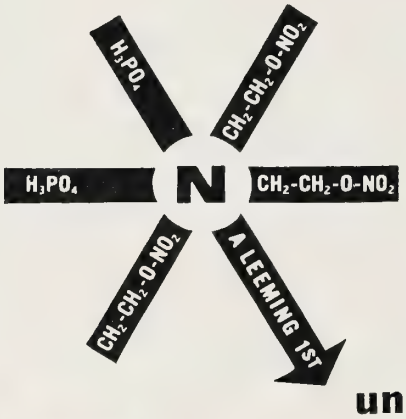
The corresponding data from Minnesota for the year 1952 shows a death rate of 0.7 per 100,000 in the age group under twenty years of age and in the age group of 50 years and older a rate of 19.4 per 100,000. The tuberculin rate in school children in Minnesota is now about three per cent in contrast to 50 per cent for adults over 50.

Larger samples of tuberculin tests especially among adults of different ages are needed. When the data are available it may be possible to predict from the percentage of positive tuberculin reactors the expected annual number of new cases and of deaths from tuberculosis.

As the program for the elimination of tuberculosis progresses, intensive X-raying of certain segments of the population will probably replace general mass X-ray surveys. Repeated annual X-rays on males over 40 and females over 60 would yield many active cases of tuberculosis, of carcinoma of the lung and of heart disease.

(*Continued on page* 90)

Angina pectoris prevention



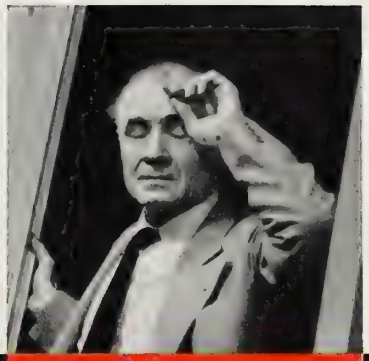
Most efficient of the new long-acting nitrates, METAMINE prevents angina attacks or greatly reduces their number and severity. Tolerance and methemoglobinemia have not been observed with METAMINE, nor have the common nitrate side effects such as headache or gastric irritation. Dose: 1 or 2 tablets after each meal and at bedtime. Also: METAMINE (2 mg.) with BUTABARBITAL (¼ gr.), bottles of 50. THOS. LEEMING & CO., INC., 155 EAST 44TH STREET, NEW YORK 17, N.Y.

unique amino nitrate

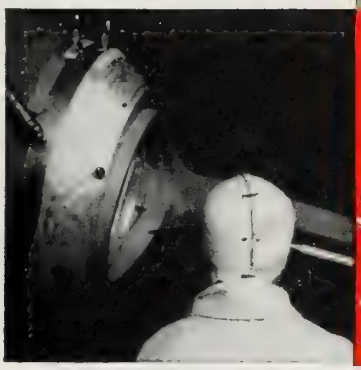
Metamine®

triethanolamine trinitrate biphosphate, Leeming, tablets 2 mg. Bottles of 50 and 500

Ménière's syndrome, cerebral arteriosclerosis, fenestration surgery, streptomycin toxicity



radiation therapy





postoperative status



motion sensitivity in every form of travel



effective
control of
nausea
vomiting
vertigo

associated with labyrinthine dysfunction

BONAMINE*

Brand of meclizine hydrochloride

Two convenient dosage forms . . . tasteless TABLETS (25 mg.) and mint-flavored, universally acceptable CHEWING TABLETS (25 mg.). Bonamine is ethically promoted. *Trademark

Pfizer PFIZER LABORATORIES, *Division, Chas. Pfizer & Co., Inc.,* Brooklyn 6, N. Y.

TUBERCULOSIS (Continued)

Ideally each individual with a positive tuberculin reaction should be X-rayed every year.

The routine X-raying of general hospital admissions has yielded from two to ten times as many active cases of tuberculosis as mass X-ray surveys in the same areas. Before long it will be more economical to carry out admission tuberculin tests on all patients under 40 years of age followed by an X-ray of all positive reactors and continue to X-ray individuals over 40. The same method of tuberculin testing and X-raying could be carried out by private practitioners of medicine.

The key to the elimination of tuberculosis is the tuberculin test which tells us which individuals have living virulent tubercle bacilli in their bodies. An annual X-ray of tuberculin reactors should detect the disease early enough to cure the patient before the infection of others. Routine annual X-rays, without tuberculin tests, should be continued for the heavily infected group of individuals who are now 40 years of age or over.

Some may be shocked by the suggestion that 50 years would be required to eliminate tuberculosis from the midwestern states. This is a conservative estimate based upon assumptions such as: no disturbance in our present high standard of living, no catastrophic war or social upheaval, an increase in case-finding programs and a maintenance of the present sanatorium system with its expensive medical and surgical treatment.

The long incubation period for the development of clinical tuberculosis explains the long time required. To this must be added the prolonged persistence of tubercle bacilli in the bodies of those who have been treated and are apparently well. All physicians can recall instances were a person was "cured" in his twenties and has remained well until he relapsed in his seventies. Even more disturbing is the young child who is infected and does not develop clinical tuberculosis until old age.

Leprosy is the only other human disease which has a comparable long incubation period and a

(*Continued on page 92*)

Lederle

GRAVIDOX*

Pyridoxine-Thiamine *Lederle*

For preventing and treating nausea and vomiting of pregnancy

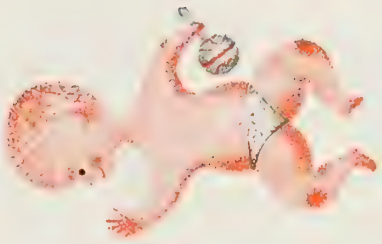
Pyridoxine (B_6) and Thiamine (B_1) have proved more effective in combination than either alone in the prevention and treatment of hyperemesis gravidarum. GRAVIDOX, in tablet and parenteral form, combines these vitamins, providing a nutritional approach to the problem. GRAVIDOX may also be useful for the prevention and relief of nausea and vomiting associated with radiation sickness.

Each GRAVIDOX tablet contains: Thiamine HCl—20 mg., Pyridoxine HCl—20 mg. Each cc. of GRAVIDOX parenteral solution contains: Thiamine HCl—50 mg., Pyridoxine HCl—50 mg.

Average dose: 5 to 12 tablets daily, in divided doses, at times when vomiting is less likely to occur; or 1 cc. parenteral solution 2 or 3 times weekly.

LEDERLE LABORATORIES DIVISION AMERICAN Cyanamid COMPANY Pearl River, New York

*REG. U. S. PAT. OFF.





Folic Acid ...and normal growth

When you prescribe a multivitamin product for an infant, a growing child, or a mother-to-be, make certain you choose one containing an adequate amount of Folic Acid. This B-complex vitamin is essential to the formation of all body cells, including red blood cells, and consequently, a vital factor in normal growth. Although essential to all, it assumes even greater importance during infancy and pregnancy.

So that you may conveniently prescribe a complete and adequate regimen for such cases, leading pharmaceutical manufacturers include Folic Acid in many of the vitamin preparations that they offer. This message is presented in their behalf.

Cyanamid Fine Chemicals

AMERICAN *Cyanamid* COMPANY

FINE CHEMICALS DIVISION

30 ROCKEFELLER PLAZA, NEW YORK 20, N. Y.



The pleasant cinnamon flavor of this children's sulfa tablet carries clear through—no bitter after-taste. Children will accept your therapy gladly because Demisulf can be chewed or will disintegrate rapidly in a teaspoonful of water.

Doctors have found Demisulf most successful for treating their young patients with a well balanced sulfa combination.

Sulfadiazine	*0.083 Gm.*
Sulfamerazine	*0.083 Gm.*
Sulfamethazine	*0.083 Gm.*
(Represents Total Sulfonamides	*0.250 Gm.)*

Try Demisulf for your next young patient. Send for your free testing sample today.

Please send me my testing sample of Demisulf along with complete information.

Name_____

Street_____

City_____ Zone____ State_____

YATES DRUG COMPANY

295-303 Lafayette Street, New York 12, N. Y.

TUBERCULOSIS (Continued)

comparable long period of infectivity. Leprosy was eliminated from Europe between 1300 and 1600 A.D. by an intensive program of isolation. It required 300 years to eliminate leprosy from Western Europe. It did not disappear spontaneously and persists even today in tropical countries.

‹ ›

Exposure to dust

Silicosis is the result of cumulative long exposure and produces a characteristic roentgenographic pattern. The history of exposure is necessary to confirm the diagnosis. Treatment is primarily removal from the irritating dust. Other silicate dusts such as asbestos, talc, and diatomaceous earth, produce disabling pneumoconiosis. Beryllium dust produces a chemical pneumonitis which differs from the other pneumoconioses because of the lack of correlation between the amount of exposure and degree of involvement. Many dusts are harmless and produce only benign pneumoconioses. Chest X-ray in these instances may show a moderate reactive fibrosis which never progresses to nodulation. These dusts are neither toxic, allergenic, nor pathogenic. The presence of these dusts produces no symptoms, no disability, and no predisposition to pneumonia, bronchitis, or tuberculosis. The disabling pneumoconioses are gradually becoming non-existent as the result of dust control measures in industry — the product of engineering and medical skill. *John F. Gardiner, M.D. Occupational Diseases of the Lungs. Nebraska M.J. August, 1955.*

‹ ›

Tuberculosis poses a real problem. The falling death rate bears no relation to the prevalence of the disease today. The low mortality means, in the light of modern therapy, that patients who formerly were carried out the hospital back door in pine boxes now walk out the front door. These individuals, with either active or inactive tuberculosis at the time of discharge, swell the number of patients in the community with a disease that continues to be chronic and relapsing despite modern chemotherapy and surgery. Theodore L. Badger, M.D., Bull. Nat. Tuberc. A., June, 1955.

AUREOMYCIN has been in daily use for seven years. It has helped fight disease on every continent, in every climate. More than 8,000 medical papers have been written about it. Many thousands of physicians regularly prescribe it with knowing confidence.

Of the many, many therapeutic agents, few have been so extensively used, so thoroughly proved as this broad-spectrum antibiotic.

OMYCIN*

Chlortetracycline *Lederle*

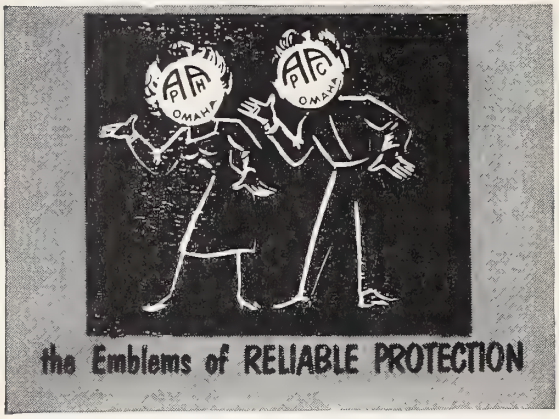
dosage forms for every medical requirement

Now available:

AUREOMYCIN SF Capsules, 250 mg.

For Patients with Prolonged Illness AUREOMYCIN SF combines effective antibiotic action with vitamin supplementation to shorten convalescence and hasten recovery. One capsule, q.i.d., supplies one gram of AUREOMYCIN and B complex, C and K vitamins in the Stress Formula suggested by the National Research Council. AUREOMYCIN SF Capsules are dry-filled and sealed, contain no oils or paste.

WE CORDIALLY INVITE YOUR INQUIRY for application for membership which affords protection against loss of income from accident and sickness (accidental death, too) as well as benefits for hospital expenses for you and all your dependents.



SINCE 1902

ALL PREMIUMS COME FROM

PHYSICIANS SURGEONS DENTISTS

ALL BENEFITS GO TO

$4,500,000 ASSETS
$22,500,000 PAID FOR BENEFITS

PHYSICIANS CASUALTY AND HEALTH ASSOCIATIONS
OMAHA 2, NEBRASKA

The disabled wife

Three out of every ten members of our labor force in this country today are women; therefore, as workers, many thousands are disabled in our industry and business. As homemakers, they are subject to accidents on a scale which seldom is realized, for homemakers, the largest single occupational group, have an accident rate 123 per cent higher than that of employed men. If we examine the causes of broken homes and the disintegration of healthy family life, disablement of the wife and mother will appear high on the list. We know that handicapping conditions are as prevalent, as serious, and as costly among women as among men, but we know also that far too little attention has been given to the rehabilitation needs of women. The disability of a wife and mother can destroy a home, cast children adrift, exhaust the husband's earnings, and produce public costs which are so large and so prolonged as to be almost immeasurable. For the thousands of women who have assumed the dual responsibilities of mother and wage-earner, a disabling condition presents especially severe problems. Of 11,500 families whose children were cared for in day-care centers in California in one year, over half the mothers were the only wage-earners in their families. Among such a group a disabling accident or illness spells catastrophe for the family and usually brings another case to the rolls of the state public assistance agency. Combined with the factor of age, the catastrophe takes on even more appalling significance. Whether it is to result in wages earned in a factory or simply to providing the intangible as well as the tangible things that a housewife furnishes, rehabilitation of women is at least as important as the rehabilitation of men. There is probably no more dramatic and moving demonstration to a community of the far-reaching effects of rehabilitation than the disabled wife rehabilitated and returned to the family circle as the homemaker and focal point of a family's life. *A. Ryrie Koch. The Economic Aspects of Rehabilitation of the Older Person. New York J. Med. July 15, 1955.*

« »

Absence diminishes little passions and increases great ones, as wind extinguishes candles and fans a fire.

—*La Rochefoucauld*

for patients with painful "creaky" joints



Pabirin . . . safest of the antirheumatic salicylate-paba combinations

For these reasons: Salicylism does not occur, even with heavy daily requirements. *Low* dosage levels produce *high* blood levels. Acetylsalicylic acid, the most effective of the salicylates, is well-tolerated. Pabirin is sodium- *and* potassium-free. It offsets salicylate depletion of vitamin C by providing a therapeutic amount of 300 mg. in the average daily dose of six capsules. **And highly effective** . . . High blood levels are promptly reached and sustained due to the mutually potentiating action of acetylsalicylic acid and PABA plus the retarding effect of PABA on salicylate excretion. Rapidly disintegrating capsules provide fast absorption and pain relief.

Pabirin is a DORSEY preparation.

Each capsule contains:
Acetylsalicylic acid ..... 5 gr.
Para-aminobenzoic acid ..... 5 gr.
Ascorbic acid ..... 50 mg.
Average dose: 2 to 3 capsules 3 or 4 times daily.
Supplied: In bottles of 100, 500 and 1,000 capsules.

Pabirin®

Smith-Dorsey • Lincoln, Nebraska • A Division of The Wander Company

for CHILDREN with EDUCATIONAL and ADJUSTMENT PROBLEMS

. . . a private resident school for children of average or superior intelligence whose psychological difficulties impair their learning abilities and school progress.

. . . enrolling children from seven to fourteen years of age. Coeducational. Small classes. Remedial reading. Brochure on request.

. . . provides a program of education with psychotherapy.

. . . out-patient psychiatric evaluation and consultation for children.

ANN ARBOR SCHOOL

A. H. Kambly M.D., Director

411 First National Building Ann Arbor, Mich.



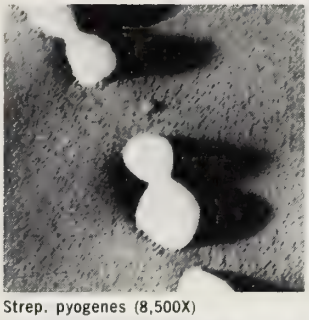
The spare kidney

The artificial kidney is indicated where the patient's uremia appears to be progressive. It is better to apply dialysis before the patient becomes too ill, because the toxic effect of uremia may affect the patient permanently. All artificial kidneys will perform the task of removing the waste nitrogens and correcting the electrolyte balance, but the Skeggs-Leonards type, which is the type we use, will do both of the foregoing and, in addition, will remove edematous fluid at the rate of 1,000 cc. per hour if required. This latter procedure is known as ultrafiltration. However, the Kolff type kidney is the most common one in use. There are more than 100 in this country, but many of them have been abandoned because of the skilled teamwork required to use it. Furthermore the Kolff kidney is large, bulky, and stationary and requires the use of the artery of the forearm to obtain blood. The Allen-Keitzer modification of the Skeggs-Leonards artificial kidney, designed for clinical use, is small, compact, portable, and mechanically foolproof. A regular team is not necessary. The use of the clinical modification is not difficult. At City Hospital in Akron, we have used the apparatus on 30 patients some 37 times and in most cases, the surgical residents have done the actual application. It is our opinion that our modification of the Skeggs-Leonards artificial kidney is the most practical method of removing the nitrogenous wastes and restoring the electrolyte balance. In addition, it is the only one that will easily produce ultrafiltration where needed. The usual time of dialysis is 4 to 6 hours. *Walter A. Keitzer, M.D. and Manley L. Ford, M.D. Treatment of Acute Uremia. Ohio M.J. June 1955.* ‹ ›

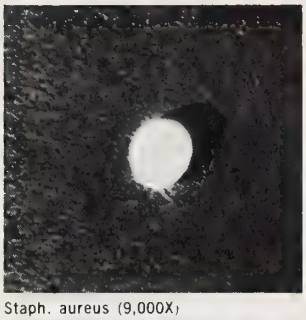
If one were to use as criteria the amount of life spoiled by disease, instead of measuring only that destroyed by death; or the number of days lost from pleasure and work because of so-called minor ailments; or merely the sums paid for drugs, hospitals, and doctors' bills, the toll exacted by microbial pathogens would seem very large indeed. Microbial diseases have not been conquered. Rather, scientists have resigned themselves to the belief that a relative protection against them can be had only at the cost of a huge ransom. Rene J. Dubos, Ph.D., J.A.M.A., April 23, 1955.

The organisms commonly involved in

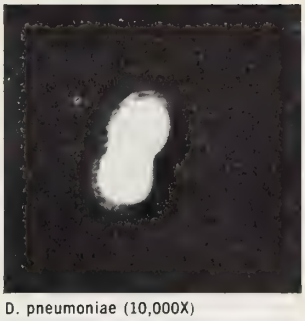
Acute Pharyngitis



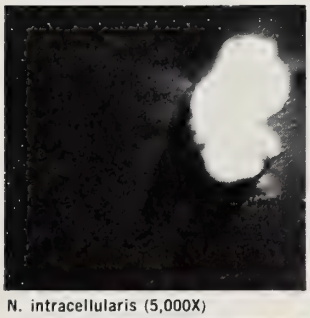
Strep. pyogenes (8,500X)



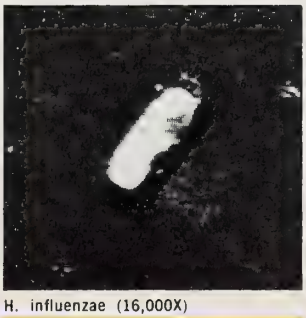
Staph. aureus (9,000X)



D. pneumoniae (10,000X)



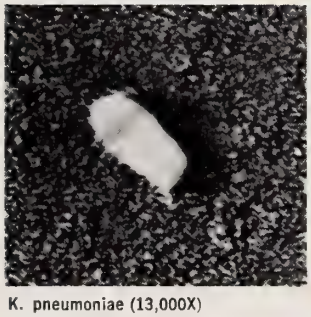
N. intracellularis (5,000X)



H. influenzae (16,000X)



C. diphtheriae (6,000X)



K. pneumoniae (13,000X)

Upjohn

ELECTRON MICROGRAPHS

***All* of them are included in the more than 30 organisms susceptible to broad-spectrum**

PANMYCIN*

HYDROCHLORIDE

100 mg. and 250 mg. capsules • 125 mg. and 250 mg./tsp. oral suspension (PANMYCIN Readimixed)
100 mg./cc. drops • 100 mg./2 cc. injectable, intramuscular
100, 250, and 500 mg./injection, intravenous

*TRADEMARK. REG U S PAT OFF — THE UPJOHN BRAND OF TETRACYCLINE

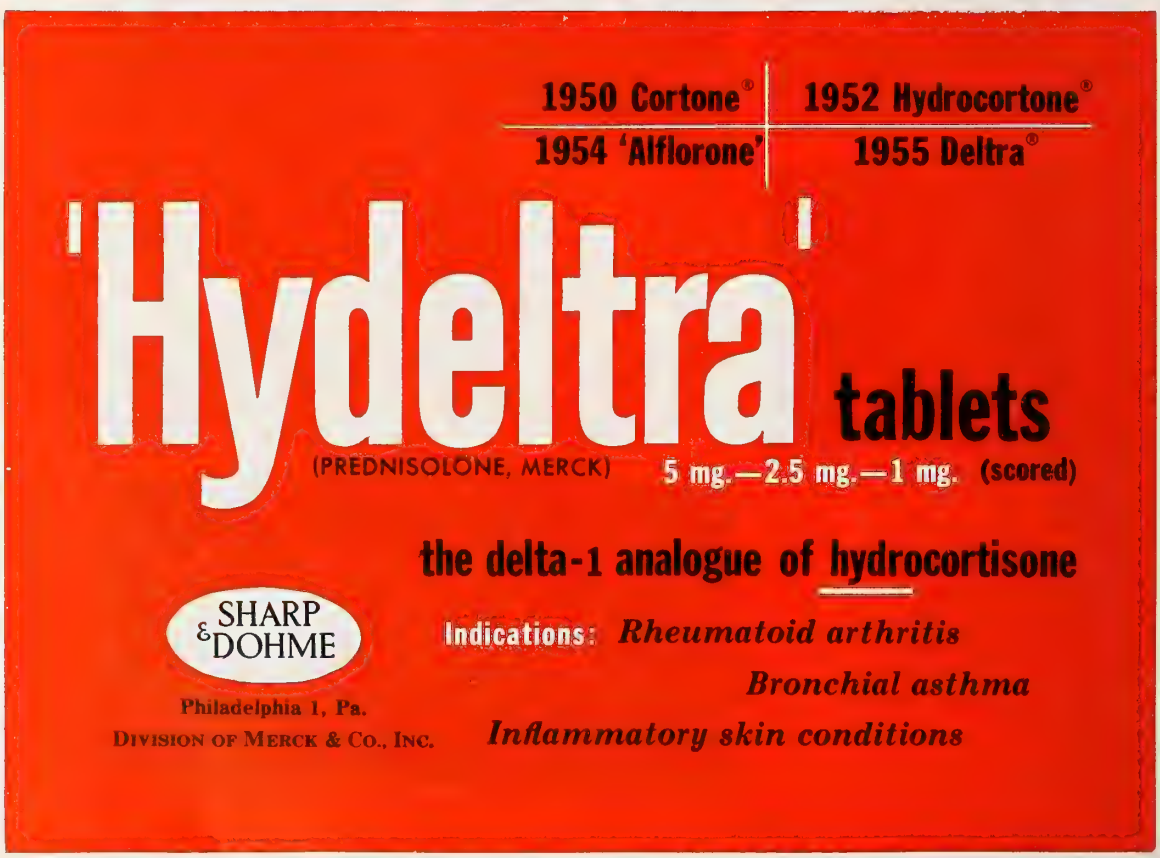
The executive

Some people become administrators by chance; others do so by outliving their competitors. Still others choose administrative work for a career. Those who succeed seems to have certain motivations for their choice and certain personal traits that account for their success. The motivations consist of deriving a sense of well being and security from knowing how to get others to do things that are worth while. Success in achieving this seems to date back to earlier experience with parents and siblings when the individual learned to handle with ease and spontaneity the problems of his early relationships. There are highly intelligent and resourceful people, capable of formulating excellent plans, who have no idea how to interest or induce anyone to carry out their ideas. Others, less well endowed, perhaps, may do so readily. This personality difference is of great importance and warrants further definition and study. One finds this sometimes in professional men who, capable as they may be, are unable to handle interpersonal relationships at all and fail. Success in interpersonal relationships does not depend upon intellectual endowment; it depends upon emotional maturity, which is the sine qua non for successful relationships with others. *Francis J. Braceland, M.D. Emotional Problems Among Executives. Med. Ann. District of Columbia, May 1955.*

« »

Breast feeding

Many influences have crept into modern living to sway the mother from breast feeding her child. Some mothers have accepted the common practice of artificial feeding as more convenient and adapted to their way of living. Many others do not understand the advantages of breast feeding and have not had them explained to them. More frequently than is recognized the father is the strong advocate for artificial feeding for many unsound reasons. Breast feeding cannot be done by the unstable or selfish mother or without the active support of her husband and doctor. Parents cannot learn too soon that they must give of themselves to provide emotional growth of their child. *Robert L. Jackson, M.D. Nutritional Management of Infants and Children. J. Missouri M.A. August, 1955.*



Better Patient Cooperation

Because of Simpler, More Effective Combination Therapy in hypertension

Greater Efficacy from smaller dosage

Side actions fewer and of lessened intensity

No complicated dosage schedules

Simpler patient management

Rauwiloid® + Veriloid®

A Riker Single-tablet Preparation

Indicated in moderately severe hypertension. Each tablet contains 1 mg. Rauwiloid and 3 mg. Veriloid.

Initial dosage, one tablet t.i.d., p.c. In bottles of 100 tablets.

Rauwiloid® + Hexamethonium

A Riker Single-tablet Preparation

Indicated in rapidly progressing, otherwise intractable hypertension. Each tablet contains 1 mg. Rauwiloid and 250 mg. hexamethonium chloride dihydrate.

Initial dosage, one-half tablet q.i.d. Available in bottles of 100 tablets.

Riker LABORATORIES, INC., LOS ANGELES

The NORBURY SANATORIUM

JACKSONVILLE, ILLINOIS — INCORPORATED and LICENSED

For the Treatment of Nervous and Mental Disorders

FRANK GARM NORBURY, M.D., Medical Director
HENRY A. DOLLEAR, M.D., Superintendent
FRANK B. NORBURY, M.D., Associate Physician

Address Communications — THE NORBURY SANATORIUM, Jacksonville, Illinois

A problem to face

A reluctant realization of the fact that there is no adequate protection from a thermonuclear blast has necessitated an entirely new concept of civil defense, so-called, no less disturbing than the old one of hurrying to the least ineffective available shelter. For there is now no hiding from the effects of a sundered atom. Flight alone has become the order of the day if there is sufficient time for flight in the event of an attack, and with the changed order comes a new set of rules to follow. Certain highways are no longer reserved for the influx of defensive personnel and material; when Rome is threatened all roads lead away from Rome, the city is left to those too calloused to flee or incapable of it, and the ways of egress become choked with humanity, possibly in panic — for nothing breeds panic so much as flight. *Editorial. Operation Evacuation. New England J. Med. August 4, 1955.*

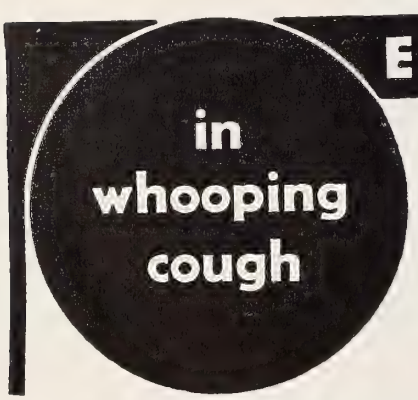
‹ ›

Family doctor

Probably the most effective thing that a family can do in regard to the preservation of its own health is to obtain a family doctor. Recently it was estimated that 70 million Americans did not have a so-called family doctor for their families. It is much too late when someone is desperately sick at midnight to try to find a doctor who will want to come to that home. Doctors almost universally are overworked today and a new patient, even an emergency, often poses the problem to the doctor of taxing himself beyond his physical capacity. But if the doctor has this family as one of his regular clientele, or at least has met the members so that he knows them, he will be more inclined to serve that family in its time of need. *Brooker L. Masters, M.D. Health Responsibility of the Rural Family. Pub. Health Rep. July 1955.*

‹ ›

Tuberculosis is a cyclical disease. It has had epidemic phases. It advances and retreats for reasons about which we are not fully informed. The wise man, remarking this, will avoid being unduly dogmatic about our progress. It is not enough to improve social conditions unless we fortify the individual man and woman with knowledge. This will take even longer than the mere changing of physical conditions. Harley Williams, M.D., Nat. Tuberc. A. Tr., May, 1954.



ELIXIR BROMAURATE

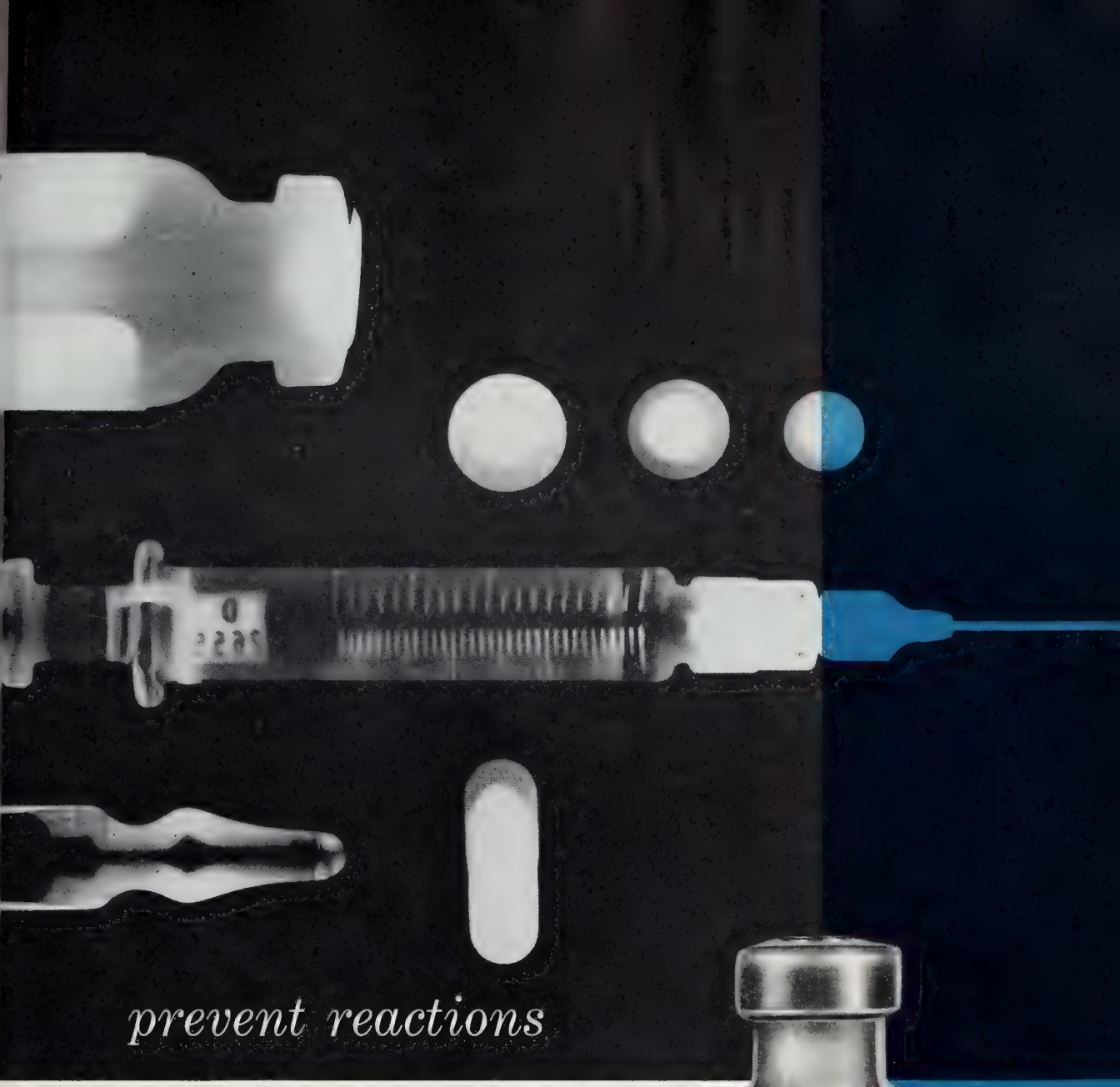
IS A UNIQUE REMEDY OF UNIQUE MERIT

Cuts short the period of illness and relieves the distressing spasmodic cough. Also valuable in Bronchitis and Bronchial Asthma.

In four-ounce original bottles. A teaspoonful every 3 to 4 hours.

Prescribed by Thousands of Doctors

GOLD PHARMACAL CO. — NEW YORK CITY



prevent reactions

protect your penicillin therapy...



To safeguard your patients add 1 cc. of CHLOR-TRIMETON Injection 100 mg./cc. to each 10 cc. vial of aqueous penicillin.

Supplied: 2 cc. multiple-dose vial. For intramuscular and subcutaneous administration.

CHLOR-TRIMETON® maleate, brand of chlorprophenpyridamine maleate.

CT-J-58

North Shore Health Resort

on the shores of Lake Michigan
WINNETKA, ILLINOIS
NERVOUS and MENTAL DISORDERS
ALCOHOLISM and DRUG ADDICTION
Modern Methods of Treatment
MODERATE RATES

Established 1901 — *Fully Approved by the*
Licensed by State of Illinois — *American College of Surgeons*

SAMUEL LIEBMAN, M.S., M.D.
Medical Director

225 Sheridan Road — Winnetka 6-0211

Steroid research

From data now available from clinical experience, it is apparent that ACTH and cortisone have extensive potentialities for research and limited therapeutic application in the treatment of cancer patients. The hormones are valuable in carefully selected cases of acute leukemia, myeloma, and malignant lymphoma. Carefully controlled therapy, under research conditions, may elucidate further the nature of the reaction of the organism to neoplastic growth and may increase knowledge of the biologic characteristics of cancer. Newly developed derivatives of cortisone and hydrocortisone exhibit greatly increased potency with fewer undesirable effects. It may be, therefore, that some of the complications of ACTH and cortisone therapy will be circumvented. *ACTH and Cortisone Therapy. Cancer Bull. May-June 1955.*

« »

Psoriatic arthritis

Psoriasis occurs in approximately 8 per cent of arthritics. Psoriasis arthropathica occurs in association with rheumatoid arthritis, rheumatoid spondylitis, and Still's disease. Psoriasis accompanies a severe, deforming rheumatoid type of chronic multiple arthritis, associated with extensive, recalcitrant lesions. Psoriatic arthritis characteristically involves both large and small joints. It may single out the distal interphalangeal articulations, in which case there is invariably psoriatic nail involvement. The arthritis parallels the cutaneous psoriatic remissions and exacerbations. *Maurice J. Costello, M.D. Cutaneous Manifestations of Systemic Diseases. New York J. Med. July 15, 1955.*

« »

Osler as a psychiatrist

Sir William Osler was one of the most effective psychotherapists I have ever seen in action; and yet, during some 200 hours as a student under his teaching, I never heard him use the word psychotherapy, or offer any specific directions for applying it. He exemplified it in every contact with his patients. *C. B. Farrar, M.D. Psychotherapy. M. Bull. Henry Ford Hos. June,* 1955.

FAIRVIEW
Sanitarium

DEVOTED TO THE ACTIVE TREATMENT OF

MENTAL and NERVOUS DISORDERS

Specializing in Psycho-Therapy, and Physiological therapies including:

- **Electro-Shock**
- **Electro-Narcosis**
- **Insulin Shock**
- **Carbon Dioxide Therapy**

Out Patient Shock Therapy Available

ALCOHOLISM Treated by Comprehensive Medical-Psychiatric Methods.

2828 S. PRAIRIE AVENUE, CHICAGO 16 J. DENNIS FREUND, M. D., Medical Director

Phone VIctory 2-1650 — **Registered by the American Medical Assn.**

DUAL *anti-infective* *anti-inflammatory* ACTION IN DERMATOSES

TERRA-CORTRIL*

rand of oxytetracycline and hydrocortisone

topical ointment

Pfizer

supplied: in ½-oz. tubes; 3% oxytetracycline hydrochloride (TERRAMYCIN®) and 1% hydrocortisone, free alcohol (CORTRIL®) in a specially formulated, easily applied ointment base.
also available: CORTRIL Topical Ointment and CORTRIL Tablets.

PFIZER LABORATORIES *Division, Chas. Pfizer & Co., Inc. Brooklyn 6, New York*

*Trademark



Mercy Hospital Institute of Radiation Therapy

The Henry Schmitz Medical Group

For Appointment
Victory 2-4700, Ext. 170 or RAndolph 6-4444

Herbert E. Schmitz, M.D., *Director*
Peter A. Nelson, M.D., *General Oncology*
Henry L. Schmitz, M.D., *Internal Medicine*
Janet Towne, M.D., *Gynecology*
Robert L. Schmitz, M.D., *General Surgery*
John F. Sheehan, M.D., *Pathologist*
Charles J. Smith, M.D., *Gynecology*
Charles S. Gilbert, M.D., *Internal Medicine*
William F. Cernock, M.D., *Internal Medicine*
Fred W. Eims, *Physicist*
Miss Hilda Waterson, R.N.
Helen Hansen, *Social Service*

COMPLETE TUMOR THERAPY
Including
SUPERFICIAL X-RAY THERAPY
DEEP X-RAY THERAPY up to 1,000 K.V.
RADIUM THERAPY

Daily Consultation at Institute
Tumor Clinic—Mercy Free Dispensary—Tuesday at 9 a. m.
Tumor Conference — J. B. Murphy Auditorium — Friday at 1 p. m.

Bleeding ulcer

Massive hemorrhage from the upper gastrointestinal tract, and particularly that from ulcer, is much more frequent in the latter decades of life. This is not generally appreciated because many bleeding ulcers are seen in middle life. However, when one considers the proportion of patients admitted to the hospital in various age groups, it will be seen that massively bleeding ulcer becomes more common with the advancing years. Thus 4 out of every 1,000 patients admitted to the hospital between the ages of 40 and 49 have an ulcer with massive hemorrhage, rising to 8 for 1,000 patients admitted between the ages of 50 and 59, at which time a plateau is reached that continues through the ninth decade. *Claude E. Welch, M.D. et al. Surgical Management of Massive Acute Upper Gastrointestinal Hemorrhage. New England J. Med. June 2*, 1955.

‹ ›

A man who is at the top is a man who has the habit of getting to the bottom.

— Joseph E. Rogers

Another Lederle "First"!

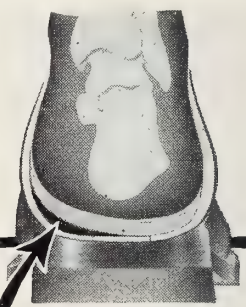
MUMPS VACCINE

A practical immunizing antigen for prevention of mumps in children or adults where indicated. Immunizes for about one year.
Packages: 2 cc. vial (1 immunization),
10 cc. vial (5 immunizations).

LEDERLE LABORATORIES DIVISION
AMERICAN Cyanamid COMPANY
PEARL RIVER, NEW YORK

Lederle

Foot-so-Port Shoe Construction and its Relation to Weight Distribution



- Insole extension and wedge at inner corner of heel where support is most needed.
- Special Supreme rubber heels are longer than most anatomic heels and maintain the appearance of normal shoes.
- The patented arch support construction is guaranteed not to break down.
- Innersoles are guaranteed not to crack, curl, or collapse. Insulated by a special layer of Texon which also cushions firmly and uniformly.
- Foot-so-Port lasts were designed and the shoe construction engineered with orthopedic advice.
- **NOW AVAILABLE! Men's conductive shoes. N.B.F.U. specifications. For surgeons and operating room personnel.**
- By a special process, using plastic positive casts of feet, we make more custom shoes for polio, club feet and all types of abnormal feet than any other manufacturer.

Write for details or contact your local **FOOT-SO-PORT** *Shoe Agency. Refer to your Classified Directory*

Foot-so-Port Shoe Company, Oconomowoc, Wis.

the delta-1
analogue
of
cortisone

Deltra®

(Prednisone, Merck)

tablets

5 mg.—2.5 mg.—1 mg. (scored)

Deltra

Indications: *Rheumatoid Arthritis*
Bronchial Asthma
Inflammatory Skin Conditions

Deltra is effective in one-fifth the dose of cortisone . . . salt or water retention rarely occurs with recommended doses . . . and patients can usually be maintained without the inconvenience of a salt restricted diet.

Deltra is supplied as 5 mg.—2.5 mg.—1 mg. (scored) tablets for precise control of dosage; bottles of 30 and 100 tablets.

SHARP & DOHME

Philadelphia 1, Pa.
DIVISION OF MERCK & CO., INC.

DELTRA *is the registered trade-mark of Merck & Co., Inc. for its brand of prednisone, supplied through Sharp & Dohme, Division of Merck & Co., Inc.*

BELLEVUE PLACE

For
NERVOUS and MENTAL DISEASES

★

Edward Ross, M.D., Medical Director
BATAVIA PHONE
ILLINOIS BATAVIA 1520

THUMBSUCKING

since infancy caused this malocclusion.



THUM TRADE MARK

THUM broke the habit and teeth returned to normal position.

ACCEPTED FOR ADVERTISING IN PUBLICATIONS OF THE AMERICAN MEDICAL ASSOCIATION

Get Thum at your druggist or surgical dealer.
Prescribed by physicians for over 20 years.

Classified Ads

RATES FOR CLASSIFIED ADVERTISEMENTS—For 30 words or less: 1 insertion, $3.00; 3 insertions, $8.00; 6 insertions, $14.00; 12 insertions, $24.00; from 30 to 50 words: 1 insertion, $4.00; 3 insertions, $10.50; 6 insertions, $20.00; 12 insertions, $30.00. Extra words: 1 insertion 10c each; 3 insertions, 25c each; 6 insertions, 40c each; 12 insertions, 50c each. A fee of 25c is charged for those advertisers who have answers sent care of the Journal. Cash in advance must accompany copy.

FOR RENT: Cheerful daylight Dr. office. Two bus line transfer corner. Two or four room suite. Newly decor. Reasonable rent. One mo. free. Druggist will coop. Phone DIckens 2-1321.

WANTED: Young gen'l pract. in new air-cond. clinic. Starting salary $600 per month plus comm. Partnership to follow after probat. period. Box 229. Ill. Med. Jl. 185 N. Wabash, Chicago 2.

PEDIATRICIAN: 31- board elig.-category 4. Married, one child. Trained Cook County Hosp. & Children's Memorial Hosp., Chicago. Priv. pract. experience. Desires location in Illinois. (Midwest) Box 228. Ill. Med. Jl. 185 N. Wabash Ave., Chicago 2.

FOR RENT: Three air-cond. suites. Three attract. functional rooms each. For non-competing M.D.'s. Busy ethical pharmacist will cooperate. Estab. over 40 years. Deitch Pharmacy, 1800 W. Chicago Ave., HU 6-2937.

It is a socialist idea that making profits is a vice. I consider the real vice in making losses.
— Winston Churchill

C S D

A case of cat scratch disease manifested by hitherto unreported generalized lymphadenopathy is reported. The typical clinical manifestations plus positive skin reaction to the antigen leave little doubt as to the diagnosis. The presence of generalized lymphadenopathy, therefore, need not deter one from making the diagnosis of cat scratch disease. *Albert Gubnitsky, M.D. and Julius M. Waghelstein, M.D. Cat Scratch Disease Manifested by Generalized Lymphadenopathy. Maryland M.J. July, 1955.*

‹ ›

We have no more right to consume happiness without producing it, than to consume wealth without producing it.
—*George Bernard Shaw*

THE SPECIAL DISABILITY PLAN AVAILABLE TO MEMBERS OF THE ILLINOIS STATE MEDICAL SOCIETY Offers You — —

INDEMNITY FOR TOTAL LOSS OF TIME payable for up to
LIFETIME if due to an accident
7 YEARS if due to a sickness

HOSPITAL EXPENSE BENEFIT payable up to 90 days of confinement
ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

No reduction in benefits because of other similar insurance. Full benefits to age 70 at same cost.
(All benefits subject to provisions of the policies)

FOR ALL THE FACTS — — — WRITE OR TELEPHONE
PARKER, ALESHIRE & COMPANY
175 W. Jackson Boulevard
Chicago 4, Illinois WAbash 2-1011

THE KEELEY INSTITUTE
DWIGHT, ILLINOIS

Treating alcoholism and other problems of addiction.
REGISTERED BY THE AMERICAN MEDICAL ASSOCIATION—
MEMBER AMERICAN HOSPITAL ASSOCIATION.

Table of Contents

DECEMBER, 1955
Vol. 108, No. 6

Editor
Harold M. Camp
Monmouth, Illinois

Associate Editor
Theodore Van Dellen
Chicago, Illinois

Business Manager and Managing Editor
Mr. L. E. Malley
185 N. Wabash Avenue
Chicago 1, Illinois

Business Office
185 N. Wabash Avenue
Chicago 1, Illinois

Editorial Office
Medical Arts Building
Monmouth, Illinois

Send original articles and membership correspondence to Harold M. Camp, Monmouth, Ill.

Send changes in the mailing list to Managing Editor, 185 N. Wabash Ave., Chicago 1, Ill.

Subscription price of this JOURNAL to persons not members of the Illinois State Medical Society is $4.00 per year, in advance, postage prepaid, for the United States, Cuba, Puerto Rico, Philippine Islands, Hawaiian Islands and Mexico. $5.00 per year for all foreign countries included in the postal union. Canada, $4.50. Single current copies 50 cents. By mail, 60 cents.

Index to Volume 108 369

ORIGINAL ARTICLES

Transfusion Therapy—Progress and Problems,
1. Clinical Aspects. Kurt Stern, M.D., Chicago 315
Cardiac Arrhythmias, Their Prognostic Significance in Recent Myocardial Infarction. Morris Binder, M.D., and Maurice W. Sbertoli, M.D., Evanston 321
Panel on School Health and the Family Physician—
Health of School Children, George L. Drennan, M.D., F.A.A.P., Jacksonville 325
Accident Prevention in Childhood, James B. Gillespie, M.D., Urbana 327
The Approach of Organized Public Health with Particular Emphasis on Relationships, Edward M. Thompson, M.D., Clinton 330
The Role of the Physician in the Pharmaceutical Industry, (Seminar), Irwin C. Winter, Ph.D., M.D. 334
The Extent and Depth of the Retrolental Fibroplasia Problem, Arlington C. Krause, M.D., Chicago 337
Massive Inversion of the T Wave (Cook County Hospital Case Records) Edwin E. Goldberg, M.D., Harold B. Shrifter, M.D., and L. Feldman, M.D., F.A.C.P., Chicago 341

PATHOLOGY CONFERENCES

1. Friedrich's ataxia complicated by chronic fibroplastic myocarditis, and
2. Perforation of a peptic ulcer of the stomach and sudden death, Edwin F. Hirsch, M.D., Chicago 345

EDITORIALS

Creative protein 348
Pathologic diagnostic service 349
A.M.A. study conference 349
New honors for Dr. Telford 350
Governor vetoes proposed revision (Senate Bill 247) of the Coroners Act of 1874 351
Compensating the faculties of medicine 353
Richard J. Graff, M.D. received citizens' award 354
Medicine on postage stamps 354
Doctor-hospital relationships 354
The Month in Washington 34A
Book Reviews 42A

MEDICAL ECONOMICS

Some Economic Aspects of Health Resorts, Frederic T. Jung, M.D., Chicago 355

THE P.R. PAGE 358

CORRESPONDENCE

Clinics for crippled children listed for January 360
Midwinter Seminar in Ophthalmology and Otolaryngology 360
American Board of Obstetrics and Gynecology 361
American Academy for Cerebral Palsy Officers 361
Notice of V Congress of Pan American Medical Women's Alliance . 361
Northwestern University Medical School in Radiation Physics 361
Intestinal Research Institute 361
Officers of Chicago Council of Child Psychiatry 362
Central Society of Nuclear Medicine 362

NEWS OF THE STATE 363

Entered as Second-Class Matter November 12, 1952 at the Post Office, Mendota, Illinois, under the Act of March 8, 1879. Acceptance for mailing at special rate postage provided for in section 1102, Act of October 8, 1917, authorized July 15, 1918. Printed monthly by The Wayside Press, Mendota, Illinois. Office of Publication, 1501 W. Washington Road, Mendota, Illinois. POSTMASTER — Return undeliverable copies under form 3579 to 1501 W. Washington Road, Mendota, Illinois.


the able antibiotic
AC
reliable
dependable
available

unexcelled among sulfa drugs . . . for safety

Valid tests, clinical trials, and long use proved the Triple Sulfas offer greater relative safety than single sulfas, and they compare favorably with all potent therapeutic agents in this respect. In addition, the Triple Sulfas are distinguished for their established efficacy, broad-spectrum activity, and outstanding economy. Alone or in combination with other therapeutic agents, the Triple Sulfas are available from leading pharmaceutical manufacturers under their own brand names. Remember: not all sulfas are Triple Sulfas. Ask any medical representative about the Triple Sulfa products his company offers!

TRIPLE SULFAS

Meth-Dia-Mer Sulfonamides

AMERICAN Cyanamid COMPANY
FINE CHEMICALS DIVISION
30 ROCKEFELLER PLAZA, NEW YORK 20, N. Y.



HOW Upjohn OFFERS TRIPLE SULFAS

BIOSULFA* Tablets are a combination of the Triple Sulfas and penicillin G, prepared in three strengths of penicillin—125M, 250M, and 500M. Resistance to penicillin is significantly diminished by the simultaneous use of sulfonamides, and the spectrum of activity is considerably broadened. BIOSULFA is extremely useful in treating infections such as pneumonia, tonsillitis, sinusitis, otitis media, acute mastoiditis, scarlet fever, gonorrhea, urinary infections, and enteritis associated with generalized infections in infants. Upjohn also offers Triple Sulfas in various other forms.

*Trade-Mark Reg. U. S. Pat. Off.; The Upjohn Company, Kalamazoo, Mich.

The Month in Washington



Washington, D. C.—If advance signs mean anything, the Eisenhower Administration next year can be expected to ask Congress for substantially more money for medical research, both direct research by scientists on the U. S. payroll and grants to others.

Currently the federal government is spending more money on medical research than at any time in history—almost $98 million through the National Institutes of Health alone. In addition, other millions are being spent on medical research in the Department of Defense, Veterans Administration and other agencies. Much of it is difficult to isolate in the federal budget.

A special committee named by the National Science Foundation at the request of former Secretary Hobby has been at work for some time on an appraisal of HEW's medical research programs. Its report, due before the reconvening of Congress, should be valuable to both the administration, and the appropriations committees.

A few examples of what is happening this year:

National Cancer Institute has $24.8 million to spend, about three million more than last year, with two-thirds going out in grants to nonfederal researchers. National Heart Institute also is working on a much more liberal budget, $18.7 million in contrast to last year's $16.6 million. Because of the spectacular publicity now being given to heart research as a consequence of President Eisenhower's illness, it is a foregone conclusion that next year this institute will get a great deal more money.

The Mental Health Institute is profiting by the largest single increase of any research operation, almost $4 million, from $14.1 to $18 million. Here again the prospects are for a substantial increase next year; problems of mental health are receiving much public attention, a situation that will not be ignored by Congress. Furthermore, the nationwide survey of mental health problems now about to get under way will point up the shortcomings in mental health research, and be an additional argument for more U. S. dollars.

All the other research institutes also shared in last session's Congressional generosity. The Institute of Arthritis and Metabolic Diseases has about $2.5 million more, $10.7 million instead of the $8.2 million of last year. The Institute for Neurological Diseases and Blindness went from $7.6 million to $9.86 million, the Microbiological Institute from $6.1 million to $7.5 million, and the Dental Health Institute from $1.9 to $2.1.

As has been customary with recent Congresses, Senate and House this year actually voted more money for medical research than the Bureau of the Budget permitted Public Health Service to request. That may not be the situation when appropriation bills come up next session. Secretary Folsom of the Department of Health, Education, and Welfare did not take office until Congress was about to adjourn last summer, but since then he has repeatedly gone on the record in favor of even greater U. S. expenditures for research. In October Mr. Folsom declared:

(*Continued on page* 38)

From Washington Office American Medical Association.

THIS IS

Rauwiloid®

The original alseroxylon fraction of India-grown Rauwolfia serpentina, Benth.

All the hypotensive alkaloids of Rauwolfia—not merely a single isolated substance

Free from the dross of the whole root

Gently antihypertensive

Tranquilizing

Bradycrotic

Free from undesirable side actions

Single daily dose

DOSAGE: Merely two 2 mg. tablets at bedtime. After full effect 1 tablet usually suffices. Available in bottles of 60, an average month's supply.

FIRST THOUGHT IN HYPERTENSION

Riker

LOS ANGELES

WASHINGTON (Continued)

". . . Today we find new problems and new opportunities. We find that heart disease, cancer, and arthritis are taking an increasing toll. And so today as a nation we are changing our lines of battle to fight this increase in chronic and major diseases. All the facts point to one great need. It is the need for more research—to learn how these chronic diseases are started, so they can be prevented; to learn to detect them in the early stages, so they can be cured. . ."

Again in November, addressing a conference on antibiotics, Mr. Folsom struck the same key, only this time more firmly. After noting that the U. S. now is spending over 12 times more on medical research than it was spending in 1946, he declared: "We must seriously consider making even more funds available for medical research to bring even greater benefits to humanity."

NOTES

The Joint Congressional Committee on the Economic Report may have some health legislation to offer next year as a result of a study of the problems of the low-income family, including methods of paying hospital, physician, and drug bills.

The medical and criminal problems connected with narcotic addiction have occupied the attention of two Congressional groups between sessions, subcommittees of the Senate Judiciary Committee and the House Ways and Means Committee. The latter is particularly worried over abuses it claims to have discovered in the use of barbiturates and amphetamines.

Dr. Frank B. Berry, assistant Defense Secretary for Health and Medical matters, in his annual report warns that the doctor procurement problem again may become acute, despite last summer's two-year extension of the act. He said the Department may not be able to obtain all the older physicians it needs because of the amendment barring the drafting of men over 35 if they have applied for a medical commission and been rejected on purely physical grounds. Also, Dr. Berry thinks the ratio of 3 physicians per 1,000 of troops may be too narrow a margin for safety.



For **TRIPLE SULFA THERAPY in ALL AGE GROUPS**

...SAFE—PLEASANT TO TAKE
...ACCURATE DOSAGE
...BUFFERED and VISCOLIZED
...WILL NOT SEPARATE

BUFFONAMIDE
TRIPLE SULFA SUSPENSION

TASTY, CHERRY FLAVOR and COLOR—ECONOMICAL!

There is no safer or more effective sulfonamide available! Extensive clinical trials show that triple sulfas (BUFFONAMIDE) have outstanding therapeutic efficiency among sulfa drugs.

Each Teaspoonful (5 cc.) Provides:	
Sulfadiazine	0.166 gm.
Sulfamerazine	0.166 gm.
Sulfacetamide	0.166 gm.
BUFFERED with Sodium Citrate	0.5 gm.

At Pharmacies Everywhere!
Handy 2 oz. Dispenser Pints or Gallons

BUFFONAMIDE ASSURES:
- Widest possible antibacterial spectrum
- Highest blood level...Safely and quickly
- Maximum potency in smallest dose
- Minimal side effects

TUTAG

S. J. Tutag and Company
19180 Mt. Elliott Avenue • Detroit 34, Michigan

The
ILLINOIS
Medical Journal



Official Journal of The Illinois State Medical Society

DECEMBER 1955
VOL. 108 NO. 6

Transfusion Therapy

Progress and Problems

I. CLINICAL ASPECTS

Kurt Stern, M.D., Chicago

THE fact that close to four million blood transfusions are annually administered to patients in the United States is sufficient proof for the important role of hemotherapy in medical practice of today. Successful utilization of blood transfusions requires close cooperation between three medical services: (1) the clinical practitioner who decides on the indication for and specifies details of the administration of the blood; (2) the agency which collects, processes and selects the blood. Responsibility for this activity, most commonly organized as a blood bank, rests with specialists, such as pathologists or other physicians qualified in the field; (3) the physician who actually administers the blood to the patient. While in some instances the same physician may carry on two or all three services, more frequently, especially in large institutions, a division of services exists. It is therefore important that each of the participants in hemotherapy is well aware of the special problems inherent in the other services. This paper is an attempt to outline some of the important aspects relevant to integration of hemotherapy, with emphasis on progress made within recent years as well as on problems still awaiting their solution.

Blood transfusions are closely akin to drug therapy. For this reason the following features must be considered: (I) the indication; (II) the product; (III) the administration.

I

The principal indications for use of blood need be summarized only briefly: (1) replacement of acute blood loss; (2) replacement of chronic blood loss and blood destruction, or as substitute for deficient blood formation; (3) supportive therapy in debilitating disease and as a measure to build up rapidly the hematologic status preoperatively or in convalescence.

Strict distinction must be made between indications for blood transfusions in which replacement of total blood volume is to be accomplished, and other conditions in which only certain cellular or soluble components of whole blood are needed. For instance, in most chronic anemias only red cells need be supplied, without any indication for increasing the plasma volume[1,2]. In

From the Blood Center of the Mount Sinai Medical Research Foundation and Hospital, and the Department of Pathology, Chicago Medical School, Chicago, Illinois.

Presented at the General Assembly of the Annual Meeting of the Illinois State Medical Society, May 20, 1954.

some instances, especially when the myocardial reserve is reduced, it is even to the advantage of the patient to use only red cells without addition of plasma. Thus one ensures better tolerance of the transfusion by the patient, as well as more economic utilization of blood. On the other hand, immediate replacement of blood volume can be accomplished by plasma alone, or some plasma fractions, especially serum albumin. Among other plasma fractions, fibrinogen has become an important life-saving product to be used in hypofibrinogenemia and afibrinogenemia, which may occur as serious intrapartum complication associated with abruptio placentae, resulting in severe bleeding difficult to control by any other measure[3]. Other plasma fractions are useful for treatment of disorders of the hemostatic mechanism, such as antihemophilic globulin (AHG), or are indicated in the treatment or prevention of certain infectious diseases by virtue of their content in specific immune antibodies. Within recent years it has also become possible to supply patients with a particulate component of blood which cannot be provided for in the form of routine transfusions, namely blood platelets. Platelet concentrates prepared by means of relatively simple techniques are of great value in tiding patients over acute crises of thrombocytopenic purpura and in certain stages of leukemias[4].

A few words may be in order regarding some terms that are often used interchangeably but actually refer to different products with different indications. These terms concern red blood cells remaining after removal of the plasma. Such red cells can be administered in one of two forms: (a) in the form of *packed cells* with no other suspending medium added, since the small amount of remaining plasma ensures sufficient fluidity of the material; (b) after resuspending the cells in another medium, such as physiologic saline or 5 per cent glucose in physiologic saline. The latter product is called *resuspended red cells.* Packed or resuspended red cells are indicated when (a) the main purpose of the transfusion is replacement of oxygen-carrying capacity, and/or (b) overloading of the circulation is to be avoided because of reduced myocardial reserve. When renal or cardiovascular lesions make administration of sodium chloride undesirable, packed cells are preferable to resuspended cells. In some instances, such as in some patients with hemolytic anemia and other hematologic disorders, plasma is tolerated poorly, and hence it may, in rare cases, be necessary to remove the plasma as completely as possible by washing the red cell with physiologic saline once or more times. The product of this procedure is called *washed red cells.* When deciding on the use of washed red cells, we must be aware that we are trying to make a choice between two evils: one is the possible harm to the patient resulting from presence of small amount of residual plasma, the other is the traumatic injury to red cells resulting from repeated centrifugation. Hence one should reserve use of washed red cells for those patients who do not tolerate even small traces of plasma.

Analogous to drug therapy, indications for blood transfusions must take into account the fact that untoward effects may result from the treatment. Due to this element of risk, every transfusion not fully justifiable is contraindicated. Complications of blood transfusions fall into three categories: (1) Transfusion reactions. Among them, pyrogenic and allergic reactions can be reduced to a certain minimum but cannot be completely eliminated even in the best run transfusion service, where they occur in from 2 to 3 per cent of all transfusions[5]. (5). Although these reactions are rarely serious, they may aggravate the course of disease in already seriously ill patients. (2) Isosensitization. Even when the most modern and cautious laboratory procedures are used in selection and crossmatching of blood, occasionally the recipient may develop sensitization to a blood factor not possessed by him but present in the transfused blood. This potential hazard has vastly increased within recent years because of the frequent use of multiple transfusions. Isosensitization initiated by transfusions is especially serious for women since in a future pregnancy the fetus may carry the same antigen for which the mother has antibodies, thus increasing the likelihood of fetal erythroblastosis in the infant[6]. (3) Transmission of disease. A serious hazard, associated with every blood transfusion as well as with administration of most blood and plasma components is transmission of homologous serum jaundice[7]. Although considerable effort is made and stringent precautions are used for the

purpose of eliminating donors considered to be potential carriers of the hepatitis virus, it has not yet been possible to block completely transmission of this disease by blood transfusion. Awareness of these potential complications of hemotherapy obviously prohibits use of blood transfusions as placebo intended merely as method for raising the morale of the patient or his family.

II

Several important aspects of hemotherapy concern special features of the product involved. Questions are frequently raised pertaining to the age of blood intended for transfusion: in particular, requests made to blood banks indicate that some physicians believe that under certain conditions freshly drawn blood administered without any delay is superior to stored "bank" blood. Actually this is not the case. As to cellular components, leukocytes and platelets deteriorate in blood drawn by conventional methods so rapidly that they cannot be transfused successfully regardless of the time interval between donation and infusion. Platelets can be collected in a satisfactory manner if the blood is drawn into containers with non-wettable surfaces, and then they are resistant to storage for a limited period[4]. Labile components present in the liquid portion of blood, such as complement, antibodies, and factors involved in hemostasis, do not deteriorate appreciably during the first week of storage. The maximum useful life at present of whole blood is 21 days; this period was established on the basis of studies on survival of tranfused red cells. When maximum survival of red cells is mandatory, such as in aplastic anemias, replacement transfusions of erythroblastotic babies, or when transfused red cells will be exposed to hemolytic mechanisms, such as in immune hemolytic anemia, or when blood is intended to correct defects of the hemostatic process, blood not older than 2 or 3 days should be given.

The perishable nature of blood must be kept in mind in order to avoid serious economic losses which may result from unnecessary requests for blood. We must keep in mind that a unit requested for a particular patient for a particular date thereby is tied up and not available for another patient; also, if it is ultimately decided not to use this blood for the particular patient, a considerable fraction of its useful life has been lost and the likelihood has increased for its having to be discarded because of overage. Hence, great care should be exerted by the physician in his orders for blood, and notice of cancellation of a specific request for blood should be given to the blood bank at the earliest possible moment.

In the ideal selection of blood, donor and recipient have identical ABO and Rh types. If this condition cannot be realized, the following minimum requirements must be met; (a) every Rh-negative patient must receive Rh-negative blood; (b) blood of group O, the so-called "universal donor", may be given to patients of other ABO groups provided it has been established as "safe" by certain laboratory procedures.

This brings us to the important item of "emergency transfusions", that is administration of blood without previous laboratory tests, such as typing of the recipient and crossmatching with the selected unit. Commonly O Rh-negative blood, preferably free of immune isoagglutinins, is used for such emergency transfusions, sometimes with addition of so-called group-specific substance intended to neutralize the isoagglutinins. Doubtless situations arise in medical practice where administration of blood without the delay caused by pretransfusion laboratory tests may be life saving. However, the physician ordering blood for such a purpose must be aware that he is operating with a calculated risk, since there is no blood that can be assumed to be universally safe without preceding tests. The increasing use of blood transfusion and the frequency of multiple transfusions have greatly enhanced the likelihood for isosensitization. Performance of sensitive pretransfusion tests for detection of immune hemoantibodies is therefore an essential prerequisite for safe hemotherapy. Hence, administration of blood without pretransfusion tests carries the immediate risk of hemolytic transfusion reactions caused by such unsuspected and undetected antibodies, as well as the delayed risk of isosensitization.

While the preceding remarks have emphasized that no blood can be considered a priori as universally safe, it may be even more surprising that some blood is selectively unsafe for certain recipients only. This refers to the fact that a woman should never be transfused with the blood of her husband, her children or of the husband's blood relatives. This interdiction is

based on numerous instances recorded in the literature where isosensitization to otherwise rarely involved blood factors occurred in women who were exposed to a powerful combination of two antigenic stimuli: pregnancy with a fetus carrying a hemoantigen absent in the patient, preceded or followed by transfusion with blood containing the same antigen, which is most likely to be the case with blood of husband or childen[8].

A final important point in proper utilization of blood concerns dosage, that is, the quantity to be given. It is common practice to use 500 ml., or a pint, for each transfusion, because this is the amount of blood that can be safely withdrawn from the healthy donor. However, obviously this does not imply that it is also the most suitable amount of blood to be administered to every patient. On the contrary, there are numerous instances, where it is much more advisable to give smaller amounts of blood at frequent intervals, such as quantities of 100 ml. of blood daily or every other day. This has been strongly emphasized by Davidsohn[9] in recent years, especially pertaining to hemotherapy of patients with hemolytic anemia, leukemia, and other hematologic disorders. Reports from the Mayo Clinic[10] indicate that this is also true for patients with anemia due to chronic nephritis. Small amounts of blood are as a rule much better tolerated by these patients, and fractionated transfusions are less likely to cause harmful side effects.

III

The last aspects to be discussed concern certain important considerations relating to administration of blood. (1) Every transfusion is a surgical procedure, necessitating observance of strict asepsis of technic. (2) The sterility of the blood must be preserved. Blood is not only perishable, but also represents an excellent medium for bacterial multiplication. This hazard increases with the length of time elapsing between the moment the blood is removed from refrigeration until it is administered to the patient. If an appreciable delay occurs in administration after the seal has been broken, such blood should not be used. (3) Excessive speed of administration can lead to serious cardiovascular embarassment, and is especially contraindicated in patients with weakened myocardium. On the other hand, rapid administration of blood is essential in cases of shock in order to replace lost blood volume. In such cases, preceding or simultaneous administration of plasma, or suitable plasma expanders, may be combined with blood transfusions. Several devices have been recommended for speeding up administration of blood under such conditions. Use of positive pressure, created by rubber bulbs, is still encountered but this is a potentially hazardous procedure due to the possible introduction of air embolism. Hence, this method must be carefully controlled by a qualified person who will interrupt the transfusion before fluid in the bottle is exhausted. Other devices presently available appear safer, such as rotary wheels which compress the plastic tubing through which the blood flows and in this way accelerate its administration so that a unit of blood can be administered in from 5 to 10 minutes. Amounts of blood administered during a given time can be also increased by infusing more than one vein simultaneously.

Within the last years considerable discussion has centered around possible advantages of intra-arterial transfusions as compared with the classic intravenous method[11–15]. There seems to be no doubt that, with proper technic, intra-arterial administration of blood can lead to near-miraculous resuscitation in cases of extreme shock. On the other hand, the technical difficulty of the procedure, and dangers such as air embolism and gangrene of limbs when arteries of extremities are used, militate against using intra-arterial infusions routinely. Most authors agree that this method be reserved for special cases, particularly in shock during operations when arteries close to the aorta are already exposed. It has been pointed out that blood used for such intra-arterial transfusions should be not more than a few days old because potassium concentrations exceeding 40 mg./100 ml. which may be present in older blod are hazardous when introduced directly into the arterial system[15].

Frequently it is necessary to combine administration of blood with some other intravenous therapy. It is important to realize that solutions compatible with blood to the extent that they may be permitted to flow through the same tubing either simultaneously or alternating with the blood are primarily physiologic saline and 5 per cent glucose in physiologic saline. Although isotonic with blood, 5 per cent glucose in water is not safe for such administration with blood, because it may cause pseudoagglutination

and hemolysis with serious consequences[16-18]. Several other intravenous solutions, such as protein hydrolysates, and vitamin supplements, should not be administered through the same tubing before or after blood transfusions, because chemicals contained in such solutions may bring about clotting or clumping of blood and thus interfere with safe administration. It is also inadvisable to inject sundry intravenous medication directly into the blood bottle or through the tubing. On the one hand, this may lead to bacterial contamination of the blood, and on the other, interactions of various chemicals with blood may bring about untoward changes and impair both chemical integrity and sterility of the blood. Some authors have recommended to add antihistaminics to blood in order to avoid or reduce allergic reactions[19]. There is some doubt in my mind whether it is justified to add a drug to every unit of blood whereas only a relatively small percentage of recipients will be benefited by it. It would seem to me more judicious to give antihistaminic medication by the usual route 10 to 15 minutes before transfusion to those patients who on the basis of past experience are likely to suffer allergic reactions from blood transfusions.

Eternal vigilance is not only the proverbial safeguard for preserving liberty, but also indispensible for assuring safety of blood transfusions. This is to imply that transfusion reactions are deprived of their most dangerous effects, if they are noted early in the transfusion, specifically before administration of more than 100 ml. Hence, patients receiving blood transfusions should be under constant observation during administration of this amount, and subsequently should be checked at intervals of 10 to 15 minutes until the transfusion is completed. Most commonly observed are the so-called allergic, or febrile (pyrogenic) reactions, which occur even under best possible conditions with a frequency of from 2 to 5 per cent. As mentioned before, reactions caused by overloading of the circulation in patients with reduced myocardial reserve can, as a rule, be avoided by adequate control of rate of administration of the blood. The most serious type, the hemolytic transfusion reaction, results from administration of mismatched blood. This may be the consequence of (a) technical errors in selection and crossmatching of blood, (b) clerical errors, with the wrong blood given to a patient because of mistaken identity, mixup in bottles, etc., (c) incompatibility not detected by presently available laboratory tests because of extremely low activity of the antibodies in vitro. The first two causes should and can be eliminated with proper management of blood banks and cooperation of the medical and nursing staff. Whenever a hemolytic transfusion reaction is suspected, it is essential to institute immediately suitable laboratory tests in order to establish the correct diagnosis. As a rule, every transfusion reaction should be followed by rechecking of all pretransfusion tests, and by examination of urine and blood serum or plasma for free hemoglobin, determination of serum bilirubin and serum urea nitrogen, since clinical symptoms alone are usually not sufficient for classifying the type of reaction.

A complication which was observed already many years ago, but was more closely investigated in recent years, is the tendency of patients to exhibit diffuse bleeding and oozing from surgical wounds and capillary bed following administration of incompatible blood. Recent studies suggest that this is due to the development of a deficiency in blood fibrinogen which interferes with the normal hemostatic mechanism. Accordingly, it was found possible to control such bleeding readily by administration of fibrinogen[20].

Administration of large amounts of citrate present in preserved blood has been suspected to be responsible for some untoward effects of transfusion. Actually numerous units of blood would have to be given within a relatively short time in order to overload the organism with the citrate ion, since this compound is rapidly metabolized by the liver. In the presence of liver disease blood citrate concentration following multiple transfusions has been found to reach levels sufficiently high to bind all ionized calcium available[21].

As mentioned previously, the plasma potassium content of blood rises with storage, especially after 2 weeks, and thus there is a danger of producing hyperpotassemia in patients with disturbed renal function[22]. Hence, such patients should be given blood stored for less than 10 days in order to avoid introduction of excessive amounts of potassium.

The preceding remarks on progress and problems in present-day hemotherapy undoubtedly

omitted some important aspects, and may have given undue emphasis to others. Nevertheless they will have served their purpose if they have pointed out some ways and means how clinical physicans, surgeons, pathologists, and other qualified persons in charge of blood banks can and must collaborate closely and understandingly in order to ensure successful utilization of hemotherapy.

REFERENCES

1. Smith, D. W., Elliott, J., and Griffits, J. J.: Specific transfusion therapy. Jackson Memorial Hosp. Bull., 5: 1-7, 1951.
2. Cazal, P.: Transfusions of red cells without plasma. Their role in treatment of anemias. Sem. des Hop. de Paris, **29**: 789-792, 1953.
3. Sawitsky, A., and Plotkin, D.: Hypofibrinogenemia and post-partum hemorrhage. Proc. 6th Meeting Am. Assoc. Blood Banks, 1953; pp. 117-128.
4. Minor, A. H. and Burnet, L.: A method for separating and concentrating platelets from normal human blood. Blood, **7**: 693-700, 1952.
5. Adams, R. C., Lundy, J. S., Seldon, T. H. et al: Annual report for 1952 of the section of anaesthesiology: Including data and remarks concerning blood transfusions and the use of plasma volume expanders. Proc. Staff Meetings, Mayo Clinic, **29**: 19-31, 1954.
6. Robinson, R., Kristiansen, J., Hunks, C. et al: Dangerous unnecessary transfusion. Canad. M.A.J., **69**: 38-39, 1953.
7. Sborov, V. M., Giger, B., and Mann, J. D.: Incidence of hepatitis following use of pooled plasma. Follow up study of 587 Korean casualties. A. M. A. Arch. Int. Med., **92**: 678-683, 1953.
8. Davidsohn, I., Stern, K., Strauser, E. R. and Spurrier, W.: Be, a new "private" blood factor. Blood, **8**: 747-754, 1953.
9. Davidsohn, I.: Indications and contraindications for whole blood and its various fractions. Am. J. Clin. Path., **24**: 349-364, 1954.
10. Odel, H. M.: Basic considerations in the management of renal disease. Proc. Staff Meetings, Mayo Clinic, **29**: 79-82, 1954.
11. Bingham, D. L. C.: Intra-arterial transfusion. Lancet, **2**: 157-159, 1952.
12. Horton, J. A. G., Inkoter, J. S., Mackenzie, A. and Pack, E. A.: Intraarterial transfusion. Brit. M. J., **2**: 1294-1297, 1953.
13. Maloney, J. V., Jr., Smythee, C. M., Gilmore, J. P. and Manford, S. W.: Intra-arterial and istravenous transfusion. Controlled study of their effectiveness in the treatment of experimental hemorrhagic shock. Surgery, Gynec. & Obst., **97**: 529-540, 1953.
14. Seeley, S. F.: Intra-arterial transfusion. U. S. Armed Forces M. J., **5**: 229-234, 1954.
15. Melrose, D. G. and Wilson, A. O.: Intra-arterial transfusion. Potassium hazard. Lancet, **1**: 1266-1267, 1953.
16. Wilson, H.: Acqueous dextrose solutions: a hazard in transfusions. Am. J. Clin. Path., **20**: 667-668, 1950.
17. Dreyfus, B. and Salmon, C.: Inconveniences of combined infusions of citrated blood and isotonic glucose. Presse med., **60**: 845-846, 1952.
18. Buschle, D. F. and Saklad, M.: A compatible solution for administration with blood. Anesthes., **14**: 53-59, 1953.
19. Ferris, H. E., Alpert, S. and Conkley, C. S.: Prevention of allergic transfusion reactions. Am. Pract. and Dig. Treat., **3**: 177-183, 1952.
20. Hardaway, R. M., McKay, D. and Williams, J. H.: Lower nephron nephrosis, with special reference to hemorrhagic diathesis following incompatible blood transfusion reactions. Am. J. Surg., **87**: 41-49, 1954.
21. Bunker, J. P., Brewster, W. R., Jr., and Beecher, H. K.: Citric acid intoxication during the transfusion of banked blood in man. Fed. Proc. **12**: 306, 1953.
22. Weisberg, H. F., Schaefer, G. L. and Kaplan, M. C.: Unpublished data.

‹‹‹ ›››

Gastrectomy

This report is based on a study of 308 gastrectomies performed by 26 surgeons at Salem Hospital, Salem, Mass., over a 15-year period [1939-1953]. Gastrectomy was performed on 38 per cent of hospitalized patients in whom a diagnosis of gastric carcinoma was made and on 22 per cent of those hospitalized because of gastric or duodenal ulcer. The same percentage of patients had a gastrectomy whether the ulcer was located in the stomach or in the duodenum. It is anticipated that gastrectomy will be offered to a larger number of duodenal ulcer patients in the future and at an earlier stage of persisting disease. A greater number of patients with gastric ulcer should have a gastrectomy—perhaps 75 per cent. *Paul R. Hinchey, M.D. Review of Fifteen Years' Experience with Gastrectomy in a Community Hospital, New England J. Med. August 4, 1955.*

Cardiac Arrhythmias—
Their Prognostic Significance in Recent Myocardial Infarction

MORRIS BINDER, M.D., AND MAURICE W. SBERTOLI, M.D., EVANSTON

THE care of patients with myocardial infarction is beset with many complicating factors influencing the prognosis of the disease. The more extensive one's experience in treating these patients, the more respect one gathers for them and the less is the tendency to prognosticate as to the final outcome. It is most important that the physician be on the alert for any complicating factor that may increase the mortality rate in a disease that already carries a high incidence of mortality, particularly if this added hazard is amenable to therapy.

All of us are aware of the serious significance of some of the complications of this malady: shock, embolization, congestive heart failure, ventricular or septal rupture, and the arrhythmias. This paper is directed toward this latter complication.

We have for some time been intrigued by the role of the arrhythmias in determining the happy or dismal outcome of acute coronary accidents, and have come to the point where we occasionally use the presence of certain arrhythmias as a factor in conditioning the relatives for a possible unhappy ending. We have, however, not reached the extreme where the presence of one isolated premature systole or of a mild tachycardia is necessarily a reason for the institution of rigid and vigorous therapy or painting a gloomy picture.

We shall see from the following survey that the outcome is seriously affected by the presence of abnormalities of rate or rhythm. Some of our observations are at variance with the findings of other investigators. One important problem—a gallop rhythm—has been omitted. This omission is deliberate, because we have been unwilling to accept the diagnosis unless heard by ourselves and because, strictly speaking, it is not an abnormality of pulse formation nor of conduction.

From the Third Medical Service, St. Francis Hospital, Evanston, Illinois

MATERIAL

The material herewith presented consists of an analysis of 300 consecutive cases of acute myocardial infarction studied and treated in a general private institution over a four year period from 1947-1951. All of the cases had one or more electrocardiograms and interpretation of the data was limited exclusively to those instances where arrhythmia was diagnosed by ECG. The study was further limited to the first four to six weeks after infarction, usually during the patient's hospital stay since it has been shown by other investigators[8-10] that after two months, the ultimate prognosis in those patients developing arrhythmias during the early days or weeks after infarction is only minimally affected. No discussion will be made of mechanisms, symptoms, or treatment, nor of age or sex, although in reference to the latter we are aware that the female patient seems to be more prone to develop irregularities than the male.[12-14]

Wherever possible an attempt was made to exclude any pre-existing arrhythmia prior to the infarction. This was not always possible and although we realize that such omissions may alter some of the figures presented, the number of such instances was small enough not to invalidate any of the conclusions.

The overall mortality for the 300 cases was 28.7 per cent, a figure similar to that mentioned by Katz[8] although quite a bit lower than the 51.5 per cent mentioned by Askey[3] or the 46 per cent noted by Woods[18]. The location of the infarct, as interpreted from the ECG, was studied and is summarized in Table I. The majority of cases could be defined as either anterior or posterior and showed an almost exactly equal mortality percentage for both locations. Where

TABLE I

Location	Total	Mortality	Percent Mortality
Anterior	148	36	24.3
Posterior	109	26	23.8
Lateral	9	1	11.1
Septal (antero- or postero-)	8	5	62.5
Atypical	26	18	69.2

the infarct was limited to the lateral wall alone, the death rate was far below the average figure; conversely, where the infarct was believed to involve the septum, the mortality was high. In a significant number of instances an exact designation of location could not be made and such infarcts were termed atypical. This group showed the greatest mortality, probably because the infarct was not the first or because it complicated pre-existing advanced coronary artery disease[8].

TABLE II

Cases	Number	Mortality	Percent Mortality
Total	300	86	28.7
Total with RSR	159	26	16.0
Total with Arrhythmias	141	60	42.5

Almost half the cases (see Table II) showed some abnormality either of the cardiac rate or rhythm. In this group the mortality was 42.5 per cent, significantly higher than the overall figure of 28.7 per cent noted above. Where the rhythm was sinus in origin without any complications either of rate or conduction, the mortality was only 16 per cent.

ANALYSIS

TACHYCARDIAS

As would be anticipated the most common disturbance encountered was sinus tachycardia which occurred in 73 patients, over half of the group with the arrhythmias (see Table III). Sinus tachycardia was defined as being present when there was a cardiac rate greater than 100. Many more cases would have fallen into this category if occurrence of sinus tachycardia at any time were included. Certainly, transient increases in rate may have occurred in every patient. However, we limited our analysis to those patients with sinus tachycardia persistent enough to be observed clinically and recorded electrocardiographically on more than one occasion.

TABLE III

Type	Total	Mortality	Percent Mortality
TACHYCARDIAS			
a) Sinus c CHF	16	7	43.7
b) Sinus s CHF	57	21	36.8
c) Sinus total	73	28	38.3
d) Nodal	5	3	60.0
e) Ventricular	3	2	66.7
PREMATURE SYSTOLES			
a) Auricular	4	0	0
b) Nodal	1	0	0
c) Ventricular	14	6	42.8
BLOCK			
a) 2nd Degree	3	1	33.3
b) "Complete"	3	1	33.3
SINUS BRADYCARDIA	6	3	50.0
NODAL RHYTHM	1	0	0
AURICULAR FIBRILLATION	20	13	65.0
COMBINED ARRHYTHMIAS	8	3	37.5

This group was further subdivided into those who did or did not exhibit congestive heart failure, the former comprising almost ¼ of the 73 cases. Although the mortality rate was higher when sinus tachycardia and congestive heart failure were in combination it was hardly significantly greater than the figure for sinus tachycardia alone. Mintz and Katz[14] in their review, however, indicate that such a combination is a grave prognostic sign in recent myocardial infarction quoting a mortality of 71.4 per cent as compared to 57.1 per cent for sinus tachycardia alone.

The appearance of sinus tachycardia, therefore, should be treated with respect. It is probably more common where there has been extensive long-existent heart disease and its gravity depends on the degree of pre-existing damage and duration of the tachycardia[2].

We observed 5 cases of nodal tachycardia and 3 cases of ventricular tachycardia in our study. In both groups the mortality rate was 60 per cent or greater. Experimental work by Harris[6] indicated that, especially in the case of ventricular tachycardia, rapid elimination of this arrhythmia is important in preventing ultimate ventricular fibrillation. The extreme significance of the ventricular variety of tachycardia was underscored by Ambrust and Levine[1] who studied cases of paroxysmal ventricular tachycardia of various etiologies and found that where this arrhythmia complicated recent myocardial

infarction, 64 percent were dead in one month.

PREMATURE SYSTOLES

Nineteen cases were noted to have premature systoles of which the greatest number by far (14) were ventricular in origin. The presence of the auricular or nodal variety carried no serious prognostic significance in the small number observed. Those cases of infarction exhibiting ventricular premature systoles, however, revealed a mortality of 42.8 percent, higher than the average for the entire group. Master[12] and Rosenbaum[61], in their surveys, found no alteration in the overall mortality. Additional factors should be taken into consideration in evaluating the import of ventricular premature systoles. These include their frequency if occurring individually, the appearance of paroxysms, and the presence of multifocal origin.

BLOCK

The effect of conduction disturbance in acute coronary artery occlusion was studied by Master[13] who found an overall incidence of 3.2 per cent. It is said to be much more common in the older age group and more commonly associated with posterior wall infarcts because of the greater distribution of blood from the right coronary artery to the conduction system[5]. Frequently the sudden onset of P-R prolongation or higher degree of block may be the first and only sign of recent infarction. The gravity of the conduction disorder is apparently dependent on the rate, with the slower rates carrying the more serious prognosis. A rate of less than 40 is said to be critical.[12-13]

We encountered six cases of block of a degree higher than simple P-R prolongation, an incidence of 2 per cent with a mortality of 33 per cent. Only one of these had a rate lower than 40, a fact which may be instrumental in the lower mortality than generally quoted.

In a survey by Schwartz[17] the influence of the rate is similarly borne out.

SINUS BRADYCARDIA

A persistent sinus rate of less than 60 was noted in six patients, of whom three expired, a rather high figure in view of the experience of others.[12] Autopsies were performed in two and in neither was there any serious extracardiac factors contributory to death, although in one there was more than one recent infarct. We can offer no relevant explanation for this observation.

NODAL RHYTHM

Only one case was encountered.

AURICULAR FIBRILLATION

The second most common arrhythmia observed was auricular fibrillation, occurring in 20 cases or 6.7 per cent of the total. In this group there were 13 deaths, a rather high figure. Even more striking is the fact that of this number all the patients expired in whom the auricular fibrillation was persistent, whether accompanied by congestive heart failure or not, while in those where auricular fibrillation was transient there was only one fatality. Neither Levine[11] in his survey nor Master[12] in his, found such an unusually high mortality rate. Askey[3], however, found similarly high figures and emphasizes the importance of the persistence of this arrhythmia in ultimate prognosis.

COMBINED ARRHYTHMIAS

There were eight cases in whom one or more arrhythmia was observed (see Table IV). The mortality in this group was no higher than that for the patients with single type.

TABLE IV
COMBINED ARRHYTHMIAS

Sinus bradycardia with 1st degree A-V block
Auricular fibrillation with ventricular premature systoles
Auricular fibrillation and flutter restored to RSR with frequent auricular premature systoles
Auricular fibrillation with frequent nodal premature systoles
Frequent nodal and auricular premature systoles becoming flutter-fibrillation
Complete A-V block with auricular fibrillation (expired)
Sinus tachycardia with frequent ventricular premature systoles (expired)
Auricular fibrillation with paroxysms of ventricular tachycardia converted to RSR (expired)

CONCLUSIONS

There can be no doubt from the foregoing observations that disturbances of rate or rhythm in association with recent myocardial infarction significantly affects the mortality rate. Certain arrhythmias seem to have a more profound influence than others. These included persistent auricular fibrillation, sinus as well as nodal and ventricular tachycardia, multifocal and frequently occurring ventricular premature systoles and sinus bradycardia. It is apparent, therefore, that one should be on the alert for these complications especially in view of the newer methods

of therapy now available to the medical profession.

SUMMARY

1. One of the most important complicating factors in recent myocardial infarction is the appearance of disturbances of rate or rhythm.

2. A survey is presented of 300 consecutive cases of recent myocardial infarction.

3. The overall mortality was 28.7 per cent.

4. Cases accompanied by arrhythmias showed a mortality of 42.5 per cent; uncomplicated infarctions showed a mortality of 16 per cent.

5. The individual arrhythmias and their inpuence on prognosis is discussed.

REFERENCES

1. Ambrust C. A., and Levine S. A.,: Paroxysmal Ventricular Tachycardia, Circulation **1**:28, 1950
2. Askey J. M.: Auricular Paroxysmal Tachycardia in Association with Myocardial Infarction, American Heart Journal **37**:425, 1949
3. Askey J. M. and Neurath O.: Prognostic Significance of Auricular Fibrillation in Association with Myocardial Infarction, American Heart Journal **29**:575, 1945
4. Bean W. B.: Infarction of the Heart, Annals of Internal Medicine **11**:2086, 1938
5. Gregg: Coronary Circulation, Philadelphia, Lea and Febinger, 1950, p. 27
6. Harris A. S.: Effect of I.V. Procaine and Pronestyl upon Ectopic Ventricular Tachycardia Accompanying Acute Myocardial Infarction, Circulation **5**:551, 1952
7. Katz L. N., Mintz S. S.: An Analysis of Immediate Mortality in 572 Cases of Recent Myocardial Infarction, Journal of Laboratory and Clinical Medicine **32**:325, 1947
8. Katz L. N., Mills G. Y., Cesnero F.: Survival after Recent Myocardial Infarction, Archives of Internal Medicine **84**:305, 1949
9. Kerr J. D. O.: Heart Block in Coronary Thrombosis, Lancet **2**:1066, 1937
10. Lepeschkin E.: Modern Electrocardiography, Baltimore, Williams and Wilkins, p. 441
11. Levine S. A.: Coronary Thrombosis: Its Various Clinical Features, Medicine, **8**:245, 1929
12. Master A. M., Dack S., Jaffe H. L.: Disturbances of Rate and Rhythm in Acute Coronary Artery Thrombosis, Annals of Internal Medicine **11**:735, 1937
13. Master A. M., Dack S., Jaffe H. L.: Partial and Complete Heart Block in Acute Coronary Artery Occulsion, American Journal of Medical Sciences **196**:513, 1938
14. Mintz S. S., Katz L. N.: Recent Myocardial Infarction, an Analysis of 572 cases, Archives of Internal Medicine **80**:205, 1947
15. Parker R. L., Dry T. J., Willins F. A., Page R. P.: Life Expectancy in Angina Pectoris Journal of the American Medical Association, **131**:95, 1946
16. Rosenbaum F. F., Levine S. A.: Prognostic Value of Various Clinical and ECG Features of Acute Myocardial Infarction, Archives of Internal Medicine, **68**:913, 1941
17. Schwartz S. P.: A-V Dissociation and Adams-Stokes Syndrome in Acute Coronary Vessel Closure, American Heart Journal, **11**:554, 1936
18. Woods R., Barnes A. R.: Factors Influencing Immediate Mortality after Acute Coronary Artery Occlusion, American Heart Journal **24**:4, 1942

« « « » » »

Liver cancer

The average duration of life after onset of symptoms is extremely short in the majority of patients with carcinoma of the liver. When diagnosis is established before death, it usually is predicated upon a rapid decline of the patient's general physical condition and death may result from cachexia, liver failure, anemia from bone marrow replacement by metastases, or hemorrhage. Until more specific diagnostic methods are available, carcinoma of the liver should be tentatively considered in any patient with rapidly progressive cirrhosis, enlargement of the liver, pain in the upper abdomen, weight loss, and cachexia. Needle biopsy of a nodule or tender area in the liver may confirm the diagnosis but the involvement of the tumor can be accurately judged only at laparotomy. It is necessary, therefore, to assess each case on the basis of laparotomy findings, and to perform this procedure before denying the patient the only chance of cure. Even excision of metastatic deposits may be reasonable in selected cases. Since liver metastasis soon involves the vital structures, longer life and good palliative results may be afforded by resection or by irradiation. *Cancer of the Liver. Cancer Bull. May-June 1955.*

Panel on

School Health and the Family Physician

Health of School Children

GEORGE L. DRENNAN, M.D., F.A.A.P., JACKSONVILLE

ANY discussion of school health in Illinois should begin and end with the statement "The Health of School Children is Everybody's Business," and the only way to accomplish the goal of perfection is by "Everlasting Teamwork."

The definition of health formulated by the World Health Organization should be kept in mind: "A state of complete physical, mental and social well being and not merely the absence of disease or infirmity." All children in the state should have the benefit of adequate total health supervision from birth through adolescence to aid them in attaining such a state of health. In Illinois with its existing and potential resources, it should be possible to achieve this goal of providing total health supervision for all children.

It is said, our country's greatest heritage is our children, and that its greatest tradition is the high development of individual skills and individual initiative. In a world traveling rapidly toward collectivism, it is very easy to lose sight of the individual. Traditionally American parents have done their utmost to provide a better background and opportunity for their children than was available to them. I believe that today most people take their responsibilities of parenthood more seriously than ever before. We *know* that our children will be faced with even greater tasks and responsibilities than ours. How wisely they are prepared will determine their success.

The well being of our children is of the utmost importance now and in the future. To promote and maintain our children's health is everybody's business and demands everlasting teamwork. The time has come when we need no longer deliberate at length about principles, since these have been carefully tried out, revised, and now reasonably well established. There is no necessity for awaiting further the development of any techniques, because we have good tools and good methods with which to work. The game has been held up by the lack of that teamwork between physicians, dentists, educators, nurses, and parents and through which we will be able to harness the forces at our command and put them to work, realizing at last the fruits of what Kipling had in mind in his verse:

"It ain't the individual
or the army as a whole,
But the everlasting teamwork
of every bloomin' soul."

Interest in school health has spread across the country like an epidemic during the past several years. This interest has not been confined to any one group or to any section of the United States. Educators, physicians, dentists, nurses, parents, and many others, along with the organizations to which they belong have all been involved. Among the indications of this increased interest are the development of school health councils, the formation of school health committees in medical societies, the institution of health courses in teachers' colleges, and the holding of meetings, conferences, and institutes on school health.

Why this growing concern, this growing interest in school health? Perhaps it is because the school's opportunities for health education and its obligations for health supervision are becoming more clearly defined. Certainly the law requiring health examinations three times during school life has focused attention on this activity in Illinois. A review of some of these opportunities and obligations in order of their priority for children, may help us to think together:

1. During the school term children are confined in classrooms several hours each day.

Presented before the Joint Meeting of the Section on Preventive Medicine and Public Health and the Section on Pediatrics, 115th Annual Meeting, Illinois State Medical Society, Chicago, May 19, 1955.

This demands development and maintenance of a school environment that will promote mental and physical health.

2. The school situation brings pupils together in large groups at a time in their lives when they are very susceptible to the common diseases of childhood. This demands carefully determined policies for prevention and control of communicable diseases.
3. Even in the best organized school some accidents and sudden illness are bound to occur. This requires a carefully worked out program to cope with emergencies and to meet disaster situations.
4. The school years present an unparalleled opportunity for health education of all of our people during the formative years of their lives. This means that if we are to take advantage of this opportunity, a well organized program of health instruction is essential to lay the groundwork for healthful living throughout life.
5. Modern conditions of living encourage an arm chair or sedentary existence. This necessitates a program of physical education adapted to individual needs to provide skills that will serve as incentives to wholesome physical recreation throughout life.

Even a cursory study of these factors makes it clear that the development of a school health program is a complex task—too big for any one agency or group to achieve alone. It is obvious that the efforts of parents, teachers, nurses, physicians, dentists, and many others will be needed and that each of these has certain responsibilities.

First priority in responsibility for the health of children rests with the parents. They have the obligation to provide conditions in the home that will be conducive to health and to provide adequate medical and dental care. The family physician and dentist serve as health advisors to the family and render needed diagnostic and treatment services. The health department furnishes preventive and protective services for the entire community including school children. The school supplements and reinforces the efforts of the home and has the obligation to provide conditions and educational services conducive to health. Various voluntary health agencies make important contributions with particular emphasis on certain special health problems.

The integration of all these functions requires the closest co-operation and challenges all concerned. But in this country we have an answer to this kind of challenge. It is an answer typical of our democracy—the good old American system of teamwork. It is a system that again and again throughout history has proved superior to any other.

How can we get this kind of teamwork in school health? How can we develop school policies that will be acceptable to all those who are expected to carry them out?

There is a principle of good teamwork involved that may hold the secret of success in this project. It is, *mutual respect for each other's skills and responsibilities.*

Good teamwork demands that the educator turn to the physician and dentist for advice on the medical aspects of school health. Similarly the physician and dentist defer to the educator on questions of teaching techniques and procedures. Both seek the counsel of those trained in public health on problems in this field. And all have in mind the fundamental responsibilities of the parents for the health of their children.

Trust, faith, and good will will grow and prosper in this kind of relationship. This does not mean that there is no overlapping of responsibilities. The school has an obligation to help make health services worthwhile educational experiences for personnel can make important contributions to health instruction. In general, however, the chief task of education can be broadly defined as teaching, that of public health as preventing disease and protecting community health, and that of the medical and dental professions as providing diagnosis and treatment.

Only a program that (1) honors parental obligations, (2) preserves the administrative organization of the school, (3) recognizes the responsibilities of public health, and (4) respects the framework of the private practice of medicine can accomplish this goal.

PANEL CONTINUES ☞

Accident Prevention in Childhood

JAMES B. GILLESPIE, M.D., URBANA

ACCIDENTS are the leading cause of death in the 1 to 14 age groups, exceeding in frequency the next six most frequent causes. Each year in the United States there are an estimated two million child accidents which require medical attention. Twelve thousand or more of these accidents result in death and 40 to 50 thousand in injuries of a permanent nature. Child accident reduction is an obvious challenge to all groups and individuals in the United States who are interested in child life conservation.

Since the late 1940's there has been an increasing awareness of this urgent problem, and studies and programs to improve the situation are underway throughout the country. These involve activities along educational, engineering, and enforcement lines. Participating organizations have been health departments, the medical profession, the National Safety Council, life insurance companies, child welfare groups, service clubs, Parent-Teachers Associations, and others. Despite this aroused interest, efforts pertaining to the dissemination of appropriate information to professional and lay groups, research as to the causes of accidents, and the enactment of adequate laws for accident prevention, will need aggressive and sustained support by all groups interested in improvement of the present morbidity and mortality rates.

It would be erroneous to suggest that the focal point in accident prevention for the young child lies elsewhere than in the home. It is primarily the responsibility of parents and adult members in any household to arrange the home and premises so they are safe. Moreover, it is essential that instruction and guidance in matters of accident prevention be given by senior members of the family to the juniors early in life. Since the first five years of the child's life are spent almost entirely at home, a basic groundwork in accident prevention will not be established unless safe practices in every day living are observed at home. Parents should provide not only adequate daily protection for the young child but also training in safe conduct. The pediatrician or family physician may provide considerable assistance to parents during the early years since these infants and young children are seen rather frequently in the physician's office. On such occasions a physician, familiar with the types of accidents prevalent at various age levels, may advise practical preventive measures to be observed within and about the home.

After the youngster reaches the fifth year of age, others than the family will share in all programs which influence his behavior and conduct. At this period in the child's life the school teacher, the public school system, the school nurse, and public health department assume responsibilities in matters of safe practices and conduct for almost every child.

The application of priniciples of preventive medicine to children has brought about striking improvement in mortality from the contagious and infectious diseases. Physicians and nurses should adopt a more critical attitude toward the cause of accidents, approaching the problem much in the matter in which disease has been studied. The brilliant results obtained in preservation of child life in general could well be obscured by mounting accident tolls.

Some children appear more susceptible to accidents than others. There are relationships between both physical and emotional health and safety. Defective hearing, impaired vision, and poor muscle co-ordination, themselves no threat to life, may play a direct role in the causation of accidents. A child suspected of having one or more of these defects should be examined by a physician and appropriate treatment should be provided. When corrective therapy is not possible the child must be adequately protected from injuries and taught principles of safety as related to his defect. This is good evidence for the value of vision and hearing screening tests in the school health program. There are data which demonstrate that the child who is unhappy or lacks self-confidence may express his unhappiness in the form of hurts and injuries to himself. Any child receiving more than his share of mishaps should be considered from the standpoint of a possible emotional disturbance. Some parents

From the Department of Pediatrics, Carle Hospital Clinic and Carle Memorial Hospital, Urbana.

may need assistance in recognizing and properly caring for the emotional problems of their child. There is the occasional accident prone child in whom no obvious physical or emotional cause can be found for his frequent injuries. It is likely that some of these children suffer from subclinical physical or emotional defects.

Were it possible to purchase a "vaccine" to protect children from accidents, all parents would hasten to obtain it. There is, of course, no such formula, but there does exist much knowledge about the prevention of childhood accidents, which may serve as a "vaccine" when properly applied. A study of accident deaths to 775 preschool children revealed that motor vehicles were responsible for 34 per cent, while burns, conflagrations and explosions accounted for an additional 27 per cent.[1] Of the remainder, drownings caused 13 per cent, falls 6 per cent, and poisoning 5 per cent. Of the 267 young boys and girls killed by motor vehicles, 217 were hit or run over. The greatest number of these accidents occurred at home or in the vicinity of the home.

In a series of 491 nonfatal home accidents involving children and investigated in Rochester, New York, 48 per cent were judged to be preventable.[2] It would appear that boys require more close attention since studies indicate that the male is most accident prone.[3] Bain reports that 400 children under 5 years of age die annually in the United States from poisoning.[4] Aspirin, barbiturates, kerosene, lye, lead, and arsenic account for two-thirds of the deaths. In the state of Illinois in 1953 a total of 5,375 accidental deaths in persons of all ages was reported.[5] Of these 2,299 resulted from motor vehicles. Of the 3,076 deaths not due to motor vehicles 1,547 occurred at home. Zook[6], in a study of costs of hospitalized accidents, many being burns, to a single agency caring for children (Division of Services for Crippled Children, University of Illinois) noted that the average cost per child to the State of Illinois was $713.43. Dollars and cents figures, of course, fail to tell the complete story but are indicative of the tremendous economic losses from accidents.

The "vaccine" of safety must be administered to parents and not to the young child. The information relative to childhood accidents can be given to parents in relation to the child's growth and development for special types of accidents have an affinity for children in particular age groups. In the run about period the pediatrician or family physician should impart matters of safety education to the parents as a part of the regular office visit. It is advisable to begin the program of instructing parents as soon as the child can crawl and explore as an effort to anticipate some of the potential accidents. In this way safety is early made part of the child rearing program. Dietrich[7] in a discussion of a clinical theory of accident prevention emphasized the need for total protection in children under one year of age with increasing use of education as the child grows older. Protection is aimed at keeping the child unharmed until he can be taught. Excellent and brief brochures pertaining to the various types of accidents and their prevention in children in the various age groups have been published by the Metropolitan Life Insurance Company, the Prudential Insurance Company, and perhaps others. This material is available to physicians and to parents through the several companies.

The threats to a child's safety will vary with age and sex, the economic level of the family, the nature of his environs, the type of housing, the season of the year, and with the common good sense of his parents. Public health workers and physicians should be aware of the particular hazards in their community so that planning for family and community accident prevention will be appropriate to the area. Since public responsibility to prevent accidents increases when the child enters school, the responsibility of public health agencies to study, develop, and apply effective measures for accident prevention increases for children over 5 years of age.

Education, the essence of any program for accident prevention, should not cease at any specific age. To be effective, continuous safety programs should be conducted as part of every regular school curriculum. The school automobile driving instruction program is an example of safety instruction. Attention should be given to the safety of the school premises, playgrounds and recreational areas, traffic conditions, and the home. Safety education can be extended through press, radio, television, exhibitions and demonstrations, safety program meetings, and the distribution of suitable materials. Distribution of material may be a variety of routes. One of the

most unique has been the enclosure of safety messages with the monthly bills of telephone companies in several states, including Illinois. It is obvious that the scope of a well rounded program of safety is too great for any single organization and must depend upon the combined efforts of all individuals and agencies interested in reducing the morbidity and mortality from accidents.

The American Academy of Pediatrics has developed a subcommittee on accidental poisoning. The purpose of this committee is to develop Poison Control Centers in hospitals throughout the United States; a number of hospitals in Chicago and downstate Illinois and elsewhere in the United States are now participants in this program. A poisoning control manual prepared by this committee is now available to those who are in a position to organize and assist with a Poison Control Program. Pfizer and Company devoted a large part of its regular advertising space in the Journal of the American Medical Association on April 24, 1954 to accidents in the home. The American Standards Associations subcommittee on flammability of textiles has proposed a study of the type of textiles associated with burns in children. The high incidence of poisoning from common, pleasant tasting, household medicinal agents in young children, especially aspirin, is well known by members of the medical profession if not the laity.

In the first 500 poisoning cases reported to the Chicago Poison Control program, 84 were due to aspirin.[8] It has been proposed to the Pure Food and Drug Administration that such medicines be labelled "keep out of the reach of children" or "put in a safe place" and that salicylates should be packaged to make accidental access more difficult. These are several examples of the current attention by various organizations to accident prevention.

The prevention of childhood accidents is obviously not simple nor can the responsibility for it be shouldered by any single individual or group. The task of thousands of workers in other fields of medical activity and research is not easy but this has not proved a deterrent to an ultimately successful goal. It is the responsibility of the medical and nursing professions, particularly those sections most interested in child welfare and public health, to assume leadership in all efforts directed toward prevention of accidents in childhood.

REFERENCES

1. High Accident Death Toll Among Preschool Children, statist. Bull. Metrop. Life Insur. Co. **29**:9, June, 1948.
2. Dennis, J. M. and Kaiser, A. D.: Are Home Accidents in Children Preventable? Pediatrics, **13**:568, 1954.
3. De Crosse, J. J.: Study of 212 Home Accidents, New England J. Med., **248**:837, 1953.
4. Bain K.: Death Due to Accidental Poisoning in Young Children, J. Pediatrics, **44**:616, 1954.
5. Sagen, O. K., Ph.D. Chief, Bureau of Statistics, Department of Public Health, State of Illinois: Personal Communications.
6. Zook, R. E.: Dollar Cost of Hospitalized Accidents, Safety Education, Jan., 1953.
7. Dietrich, H. F.: Clinical Application of the Theory of Accident Prevention in Childhood. Amer. J. Pub. Health, **42**:849, 1952.
8. News Letter, Amer. Acad. of Pediat. **6**: March, 1955.

PANEL CONTINUES

The Approach of Organized Public Health with Particular Emphasis on Relationships

Edward M. Thompson, M.D., Clinton

DOCTOR DRENNAN has given his definition of school health, and indicated his impression of desirable procedures in which the practicing physician functions in the school health program. It has been stated or implied that the school health program is not the sole responsibility of any one person or any one agency within the community. The stage has been set for discussing the approach of organized public health in the development and execution of an effective school health program.

Because of special personal and wide community interest in the health of the school child, organized public health advocates the use of the "team approach". The "team" would be composed of a number of players, whose special interest and training qualifies them for team membership, *on a co-equal basis.* As you well know, teams may differ in their standing; they may be professionals or amateurs; they may differ in their performance record; they may differ in fame, popularity or public acclaim, but the fact remains — the team is made up of individual players, each of which has definite responsibility for co-operative action. Incidentally, most athletic teams are recognized under a team name. We might elect to call our school health team a *"Community School Health Council"* I would like to say just a word about the individuals composing our team and to indicate a relationship between the various members:

First, there is the parent, whom we would presume to have a vital interest in the health and welfare of his offspring. The parental interest is likely to vary widely, because parents vary widely in their training and personality. The parental interest would range from a genuine intelligent interest in the child's personal health and the forces within the community which would contribute toward maintaining optimal health for his and his neighbors' children. Other parents would have a vague interest and would do only those things for their children's health which they believe would be forced upon them by the so-called Illinois School Examination Law or the school administration, e.g., some parents would feel that they had fulfilled their responsibility when they had taken their child for a medical and dental examination. They would ignore completely the findings and recommendations of the physician and dentist. Obviously the parent, whose responsibility is great, cannot do the job alone but, for obvious reasons, the parent should be represented on the team, since he supplies the commodity over which school health is concerned—the school child.

Second, there is the school administrator and the classroom teacher. The school personnel is trained in the principles of pedagogy. They are engaged in one of the greatest of all professions—training children for life; health is an essential part of life. The schools would have the responsibility of presenting health instruction to students at the various grade levels, in such a way as to give meaning; we call this concept "functional health education". The classroom teachers and school administrators could not be expected to give physical examinations or professional interpretation of medical and dental findings. The schools have great responsibilities, but they must look to other members of the school health team for this technical and specialized service—which only the physicians and dentists can provide.

Thirdly, there are the professionals: the physicians, dentists, psychologists, etc., and there are specialized services within the professions, which would be utilized in the school health program, such as the otologist, opthalmologist, and the orthodontist.

Obviously, the professionals cannot render service unless they have access to the subjects in need of specialized service; they too cannot do the job alone and must rely on other members of the school health team for assistance, in bringing the needy subjects to them for professional services; the professionals must rely on other members of the team for education and motivation of parents as to the health needs of the children.

Fourthly, I should like to call the next member of the team, *Organized Public Health.* The fourth member is represented by the medical health officer, the public health nurse, the public health dentist, the Sanitary Engineer or Sanitarian, the mental hygienist, etc. These individuals have been trained in medical and other scientific principles, which are suitable for mass application, in promoting and preserving the public health. The Public Health Dept. is an official health agency, serving in a liaison capacity, bringing together and co-ordinating all groups interested in school health. Public health may assist in the study of problems in the area of school health; they may help in formulating a program for controlling the problems; and lastly, public health may participate in periodic evaluation of the programs to determine the effectiveness of group effort in the school health program. Here again, public health cannot function without the schools, the physicians, and dentists.

At this point, I should like to emphasize that on the team mentioned above, there is no place for the "grandstand" player, who tries to dominate the program of school health. We must remember that the team is composed of individuals of different backgrounds of interest and special training. There must be a *mutual respect* between the members of the team—one for the other. For example, in the field of school administration and classroom teaching, most physicians are laymen; in the field of medicine and dentistry, most school administrators and classroom teachers are laymen; the members of the team representing the teaching profession, medicine and dentistry must recognize that there are special interests of parents, which must be considered if the school health team is to function in harmony.

The team approach in planning the school health program is of major importance. It could not be assumed that the schools would accept a school health program designed and prepared by physicians, dentists, and public health people, without consideration of the schools' special interest; likewise, the members of the team representing the medical and dental professions, would be reluctant to accept and to participate in a school health program, which they had not helped to plan. Professional people in general, whether they be school or medical, desire a right to be represented in planning of programs in which they are expected to function. There must be a mutual respect for the opinions of each member of the team, on a co-equal basis, for best results in a community school health program.

I have spent considerable time in trying to establish the fact that there are basic and fundamental relationships between parents, children, the schools, practicing physicians, dentists, and organized public health. I should like to carry the idea of co-operative effort, as exemplified by the "team approach", a bit further by use of illustrations, representing personal experiences.

When I came to Illinois in 1949, I found what I expected to find—that the state had developed the so-called School Examination Law. This plan compared favorably to programs adopted in other states, as a result of stimulation at the National level, and based on co-operative planning by agencies representing health and education. In each instance, whether the school health program is known as the "School Health Code" or "School Examination Law" the state program represented co-operative effort between departments of public instruction, Public Health, organized medicine, and dentistry, and were patterned to some extent after the plans recommended at the national level.

In Illinois "A Basic Plan for Health Education and the School Health Program" was published in 1944, under the joint leadership of the Directors of the Departments of *Public Instruction, Registration and Education, and Public Health.* I understand that these Departments invited consultants from organized medicine and dentistry. Clair Turner, Dr. P.H., who had given leadership to this School Health Program, at the national level, served as special consultant in Illinois. Five years after "A Basic Plan for Health Education and School Health Programs" was published in Illinois I became interested in what had been accomplished under the program. In co-operation with school administrators, we developed what we called "School Health Summary Forms" on which would be recorded data for grades 1, 5, and 9, which most recently had been examined by physicians and dentists. From these summaries, we expected to make some kind of evaluation. Despite the fact that most school principals believed that they had a basic

school health record for every child, the survey revealed some interesting findings. We were particularly interested to learn what percentage of the children in Grades 1, 5, and 9 actually had school health records; how many had had dental examination; the percentage immunized against smallpox, diphtheria, and pertussis. We had hoped to obtain some conclusions relative to physical defects found and corrections made on children brought under professional care as a result of recent examination. (The health records varied so widely on recorded data of physical findings that we decided against trying to evaluate that aspect of the program) We did make the following tabulations in one county:

A) Health Records:
Grade 1—85.3%
Grade 5—81.4%
Grade 9—75.5%
(for the County as a whole based on enrollment for these grades)

B) Dental Health Records:
Grade 1—72.0%
Grade 5—72.8%
Grade 9—51.8%
(for entire County based on enrollment for these grades)

C) Immunizations:

1) Smallpox:
Grade 1—(28.6-78.6%) County average 52.97%
Grade 5—(34.1-83.3%) County average 57.4%
Grade 9—(32.5-65.0%) County average 47.0%

2) Diphtheria:
Grade 1—(53.0-100%) County average 65.6%
Grade 5—(31.7-100%) County average 66.3%
Grade 9—(12.2-78.8%) County average 53.0%

3) Pertussis:*
Grade 1—(44.4-100%) County average 67.3%
Grade 5—(39.0-100%) County average 70.4%
Grade 9—(42.5-85.0%) County average 62.8%

Using the generally accepted standard† for evaluating immunity status, i.e.:

90-100%—Excellent
80-90%—Good
70-80%—Safety Minimum
Below 70%—Below Safety Minimum,

we found that for the county, as a whole, only Grade 5 rated as high as "Safety Minimum" and for only one disease—pertussis. All the other grades under the survey study rated "Below Safety Minimum" for immunizations against smallpox, diphtheria, and pertussis.

In planning this study of school health records, it was agreed that Classroom Health Summary for Grades 1, 5 and 9 would assist in "putting the school health records to work", as a means of improving the School Health Program.

After the survey report was distributed by the Unit School Superintendents to the school principals, four school communities have conducted immunization clinics to improve their immunization status. These clinics were planned jointly between the parents, the schools, and the physicians practicing in those communities. The health department provided the biologics and nursing assistance, on request of the physicians, in the conducting of these immunization clinics. I am not suggesting this procedure as a model for each community in the promotion of its school health program, but rather to show how the members of a school health team can work co-operatively in handling a problem maintaining suitable levels of protection against preventable diseases.

The survey study brought other problems into focus, namely:

1) What can the community do about the 15-20 per cent of children who have no basic health records with medical examination?
2) What can be done about the 15 to 50 per cent of the children who have had no dental examination, or even a health record?
3) What can the community do about parents who have not or will not have their children inoculated against diseases for which there are effective antigens?

It is not the purpose of this paper to raise the philosophical question as to whether the above should be answered for every individual student in every school community. Assuming the trend in school health philosophy to be reasonable and practical, under the "Basic School Health Plan" of Illinois, we would submit these problems to the School Health Team for consideration at the community level. We might ask, "Who in reality is responsible for the health of the school child?" An obvious answer would be, "The Parent". The parent in all instances has not accepted that responsibility for one reason or another. For some children, the services implied in the above questions may be contraindicated for scientific or medical reasons. These may be joint responsibilities for the members of the team: the parent, the school, the physicians, dentists.

In closing, I would like to relate one other instance which portrays a relationship in which the physician is a key figure. It has been my

*Children who have been inoculated with pertussis vaccine or who gave history of having had the disease were considered immune in this tabulation.

†Office of Public Instruction, Illinois: Circular Series No. 81, November, 1953.

observation that all school people feel a definite responsibility for the health and safety of children while in custody of the school. In joint conferences on school health where school people are represented, the problem invariably arises, as to how to handle emergency sickness and accident cases that occur in school. When these emergencies arise, the school personnel feel they must do something. They would prefer to have organized medicine and/or organized public health, representing medicine, to present the schools with some standards to guide them in carrying out their responsibility for the safety of the school child at the time the emergency arises. In a recent conference where this subject was discussed, I stated that, in my opinion, the medical society had some responsibility in helping to formulate some standards which would provide safety for the child and protection for the school—standards and practices which could not be misused by nonmedically trained people in giving first aid care to emergency cases. A school man in the audience took issue with my statement and said that he was opposed to the idea of anyone giving the schools "orders". Perhaps the controversy grew out of the use of terms. Various terms, such as "Standing Orders", "Standard Procedures", or "Recommended Procedures" have been used in referring to the problem of emergency care of sick and injured children in school. On this problem more than any other, organized medicine has a vital interest—and here again the "team" or the Public health approach seems important in maintaining a wholesome relationship.

While many aspects of the Community School Health Program has marked nuisance value from the standpoint of the busy physician, the fact remains that the physician does have a major contribution to make. He should be represented in planning and giving direction and meaning to the School Health Program.

‹‹‹ ›››

School age accidents

An interesting report on accidents to school age youngsters was recently released by the statisticians of the Metropolitan Life Insurance Company. It was reported that school age accidents are currently causing about 6,000 deaths each year. Among boys from 5 to 14 years old the loss of life from accidents is seven times that from acute poliomyelitis, and 10 times loss from pneumonia and influenza combined. Among the boys from 10 to 14, accidents take a greater toll of lives than all other causes combined.

Although accidental death is not so common among school age girls as for boys, they account for more than one-fourth of all deaths and outrank every other cause of death in the 5 to 14 age range. As would be expected, motor vehicle mishaps are by far the leading cause of accidental death, accounting for 40 per cent of the total fatalities. It was shown in these studies that about 60 per cent of the children killed by motor vehicles were pedestrians.

Drowning ranked second as a cause of accidental death among these children, causing about 25 per cent of the fatalities. Other causes contributing in appreciable measure to the total are burns and conflagrations, firearms accidents, and falls. Accident prevention constitutes the most important factor in efforts to markedly reduce the number of these fatalities. The report states "since one out of every six of these fatalities occurs in and about the home, it is clear that parents can do much to make the lives of their children safer."

The Role of the Physician in the Pharmaceutical Industry

Irwin C. Winter, Ph.D., M.D.

Dr. Samter: New drugs now appear on the market at an amazing rate. It is imperative for us to know how they are developed, and what precautions are taken before they are released. Dr. Winter, who is confronted with these problems day after day, has accepted our invitation to discuss the steps which precede the presentation of a new compound to physicians at large.

Dr. Winter: In presenting the problems of preparing a new drug for general release, I should like to spend most of my time on the clinical evaluation of that drug. I shall begin, therefore, by defining the role of the full-time physician in the pharmaceutical industry.

However, to digress briefly from that subject, I want to make a point that, I believe, is frequently overlooked — namely, that the function of the pharmaceutical manufacturer is basically the manufacture of pure, stable, reproducible drugs and their distribution. His primary function then is not research, although research is necessary to maintain his competitive position.

Research, then, is only one of the functions of the physician in the pharmaceutical industry. These functions may be summarized as follows:

1. The responsibility for the health of employees, i.e., industrial medicine, similar to that performed in other industries; pre-employment and periodic physical examinations and preventive medicine. To discharge the latter duty properly, the physician must have a thorough knowledge of the health hazards peculiar to his industry.

2. The maintenance of professional relations:

a) Preparation of professional literature designed for the medical profession. The physician ordinarily does not prepare advertising copy although advertising is usually cleared through his office.

b) The answering of professional inquiries from physicians.

c) The supervision of the medical phase of sales training.

I would like to emphasize that the function of "Professional Relations" is of real importance to the profession as a whole and is becoming more so. Twenty years ago we were told that the time lag between a new, worthwhile idea and its general adoption was about 25 years. This, if ever correct, is certainly not the case today. I submit that the promotional efforts of the pharmaceutical industry are in part responsible for the remarkable shortening in this time lag. It seems to me that the universities might recognize and perhaps utilize the enormous effort which our industry puts into what is at least one form of postgraduate education.

3. Research:

Be that as it may, my own personal interest lies in the research functions which the physician in industry can perform. These may be described as:

a) Advice as to the areas where new drugs are needed.

b) Interpretation of laboratory data.

c) Clinical evaluation of new drugs and the continued investigation of drugs which are already on the market.

d) Extension of preliminary clinical data to medical practice.

Director of the Division of Clinical Research, G. D. Searle and Co.

SEMINAR
of the
DEPARTMENT OF MEDICINE
of the
UNIVERSITY OF ILLINOIS

Edited by:

Max Samter, M.D.
Associate Professor of Medicine

Alexander P. Remenchik, M.D.
Clinical Instructor in Medicine

It might be best to define these "research" functions of the physician in our industry by a brief outline of the steps by which a new drug reaches the market.

First of all, obviously, an idea is required—and such ideas are eagerly accepted from any source. From this stage on, the research department of the pharmaceutical manufacturer functions as a team; within limits, this is largely "directed" research. Based on the "idea", a series of new—or old—chemical compounds may be prepared, "screened" for appropriate activity and lack of toxicity in animals, and those surviving the "screen" submitted to clinical trial. It might be interesting to assess the role of the physician in the scope of the entire program.

The physician should certainly be able to recognize the disease where new drugs are most urgently needed. It is to be kept in mind that not all areas where drugs are needed can be selected for investigation, since even if successful the return on a large investment might be too small to warrant expenditure of company funds. Of course, there is "prestige value" in finding a new drug, even if the number of patients in whom the drug is indicated is small, and "directed" or not, the possibility of at least some degree of freedom of choice is recognized as a necessity for the development of a true research attitude by investigators. Still, any really successful drug not only has to pay its own way, but support the effort involved in the preparation and study of the many other compounds tested and found wanting. A precise estimate of the ratio of unsuccessful agents investigated to successful drugs is impossible; it is certainly many thousands to one.

In view of the wide range of the products which are investigated and distributed by the pharmaceutical industry, a physician associated with it must have a broad knowledge of the various fields of medicine even if that background is largely made up of "library" knowledge. We feel that he should retain and expand this skill by actual care of patients, but opinions differ on this point. Opportunities for the physician vary all the way in different companies from complete responsibility for a service in a nearby general hospital to assignments which require at best dispensary care of fellow employees and sometimes no "clinical" responsibility at all. He may carry on a limited private practice; usually his duties in the industry require his full attention.

The physician also must be proficient in determining the predictability of laboratory data: can the animal experiments be extrapolated to man? If so, to what extent? He must know how a new drug was selected; in other words, he must estimate the ability of the laboratory investigator. Are the latter's assistants competent? Are the analytical data significant? Needless to say there is some error in all experimental methods; so far as possible he should know the statistical laws which control this error.

He should also—and so should the laboratory investigator—be able to recognize when data from laboratory experiments give indication that a newly opened avenue of research may be more interesting and profitable than the original "directed" path—and to give advice on how to follow the new direction of interest.

A research background will facilitate the proper evaluation of these points and training in laboratory research (Ph.D.) often is helpful.

Since clinical trial is my personal responsibility, it represents, for me, the most important and interesting step in the development of a new drug. Such a step must of course be preceded by adequate laboratory tests which indicate probable activity and safety. The extent of such required laboratory tests depends, naturally, upon the characteristics of the drug. In other words, both the laboratory scientist and the clinical investigator must be satisfied with the "adequacy" of the experimental trials.

After the committee on new products has agreed on the decision to try the new agent in humans, the compound may then be given to a "specialist" in the field where the drug is thought to be useful. Such a limited trial adds further information about the safety of the drug for general use and may, if the drug is spectacularly effective, indicate its scope in the treatment of human disease. Furthermore, such trials (repeated in sufficient numbers) may be adequate for submission of the new agent to the Food and Drug Administration for approval, and for its introduction to the profession at large.

Unfortunately, such clinical trials are often not well enough controlled to permit valid comparison with the activity of other compounds of similar chemical structure, or with the ac-

tivity of other drugs, which though chemically unrelated, are used for the same purpose. It may take years, in fact, of general use before the true place of a drug in therapy is established. It is this circumstance which leads to the well known biphasic "curve of papers" in response to new drugs; early enthusiastic reports, followed by less favorable articles, and eventual acceptance of the drug's proper area of utility.

It seems obvious that with more precise information than that provided by the "clinical trial" the time required for this "settling down" process might be materially reduced. We have been slow in applying the known principles of bioassay to the evaluation of a new drug and in designing efficient clinical experiments in accordance with these standards which have long been accepted for basic studies. Several reasons, of course, (ethical, moral, and professional) make it difficult to insist on such a rigid experimental design. It is imperative, for instance, that one should not give a new drug to a patient without a reasonable chance that it will help him. I am certain that other examples which illustrate this difficulty will readily come to your mind. If we know, however, how a new drug affects a given function in animals, if we know how that function is altered in human disease, and if adequate methods for measuring changes in that function in the human exist, it should be possible to design and execute an experiment which would give the information which is necessary to establish the activity of a new drug.

There are two chief reasons why such studies are not carried out more uniformly:

First, they are unpopular, unfashionable, and unpleasant. Whether it is because most of us have been trained to be therapeutic nihilists or some other cause, the study of therapeutics is not highly regarded and the phrase "drug testing" or the even more reprehensible "drug screening" somehow evokes a distinctly unpleasant emotional response on the part of many clinicians. Such a response, and I acknowledge prejudice, does not seem to me to be entirely rational. We all take pride (and are not above a bit of boasting) in the really outstanding advances in therapy which have been made in the past few years. The highly active new drugs which are a part of that advance are *not* placebos, their careless use is *not* without hazard, the conditions under which they are indicated and properly used *must* be carefully delineated and applied, and if new—and needed—agents are to continue to appear "drug screening" under rigidly defined conditions *must* continue.

Perhaps we need a new and more socially acceptable term. We all would like to discover a new therapy ranking with penicillin. It might be pleasant for all of us to earn a Nobel prize. We should remember, however, that research is in large part endless repitition, often drudgery, only rarely highlighted by the great discovery.

A second reason that carefully designed bioassay technics are often omitted is that there aren't enough adequately trained clinical investigators available to use them. There are many adequately trained clinical scientists but there are more therapeutic problems than these men can handle and usually their research programs are already more than adequately filled. Again, the problems of therapeutics are not in many institutions the most popular. The exigencies of obtaining *adequate* research as well as clinical training puts a real barrier, both temporal and financial, in the way of most young men even if therapeutics is appealing to them. A few educational institutions are aware of the problem and are doing something about it. We can hope that more will follow that example.

DISCUSSION

Question: (Name of inquirer not recorded.) What is the fate of drugs which eventually are found to serve no useful purpose?

Answer: They tend to eliminate themselves. If prescriptions fall below a certain level, the manufacturer can no longer afford to produce them. Interestingly enough, prescribing appears to be habit forming: some drugs of known uselessness are prescribed by a surprising number of physicians even after they are withdrawn from the market.

Question: One of the problems in prescribing medication or in recognizing medication which has been prescribed by other physicians is the increasing stream of proprietary mixtures. Actually, most of these mixtures represent a combination of several established chemicals which are not known to have a unique effect when given together. Who decides about the prepa-

ration and distribution of these, I think we can honestly say, "shotgun" formulas?
Answer: Obviously, mixtures of drugs will not be prepared or distributed except upon a significant demand by the medical profession. They are screened like any other compound through the Committee on New Drugs; in fact, they are as a rule subject to the same rigid experimental and clinical tests as new compounds.

Question: Which in your opinion is more important in drug sales, advertising or efficacy of the product?
Answer: Advertising will sell drugs but only for a limited time. The continued acceptance of a drug, the maintenance of sales volume, is certainly dependent upon its effectiveness; and perhaps I should say the lack of anything better in its particular field of application.

« « « » » »

The Extent and Depth of the Retrolental Fibroplasia Problem

Arlington C. Krause, M.D., Chicago

RETROLENTAL fibroplasia is a common cause of blindness in children in Illinois and in the United States. It is a recent disease that made its appearance with modern methods of oxygen therapy of premature babies. The incidence of the disease has increased here and abroad during the past 18 years until it has become a major problem of blindness in children.

The disease generally results from the damage to immature retina by exposure to excessive oxygen, particularly of prematures just after birth. The usual form of the disease is severe and leads to a high degree of blindness. This is the ordinary kind of retrolental fibroplasia that is graded into five acute and five scarred types of retinal lesions by the ophthalmologists.

Presented at the combined meeting — Section of Pediatrics and Preventive Medicine and Public Health, 115th Annual Meeting, Illinois State Medical Society, May 19, 1955.

From the Division of Ophthalmology, Department of Surgery, University of Chicago.

This work was supported in part by a grant from the Douglas Smith Foundation for Medical Research of the University of Chicago, and from the Genevieve Marie Stevenson Fund of the Chicago Community Trust.

There is no simple way of acquiring information on the incidence of retrolental fibroplasia. As you know we are making a survey of retrolental fibroplasia in the State of Illinois among prematures born in the year 1952. This is a co-operative project that has the assistance of the Illinois Society for the Prevention of Blindness, Bureau of Maternal and Child Health of the State Department of Health, and the many associated medical societies. The year 1952 was chosen as a typical year of birth because retrolental fibroplasia could be reasonably detected and traced.

A preliminary report of this survey is presented here so that we have some idea of the actual incidence. Out of the 205,438 births among residents of Illinois for 1952, there were 14,635 prematures weighing less than 2,501 gm., or 5 pounds 8 ounces. Since retrolental fibroplasia occurs almost entirely in prematures below 2,000 gm., or four pounds 7 ounces and since the overwhelming number of prematures' weight was between 2,000 and 2,500 gm., the upper limit of weight at 2,000 gm. was selected to make the project workable. An unusual effort is being made to trace every child with an eye disease

who weighs less than 2,000 gm. for 1952. If it is possible everyone of these children is examined by an ophthalmologist for the five stages of retrolental fibroplasia.

Of the group of 4,900 prematures under 2,000 gm. born in 1952, 2,756 survived the first year of life. So far a 78 per cent response of 2,512 survivals has been obtained. Although the report is incomplete and much checking is still necessary, 48 cases of retrolental fibroplasia were found. The per cent of retrolental fibroplasia for the total number of responses, i.e., 1958, was 2.5 per cent or the state, 3.1 per cent for Chicago, and 2.1 per cent for downstate.

The tentative figure of 48 cases for the year 1952 is the lowest number, for more children are to be examined. Twenty-four of these children were born in Chicago and 24 downstate. This census covers retrolental fibroplasia in the severe forms. The mild form of retrolental fibroplasia for 1952 which is not, or only slightly, evident at this time and which obviously cannot be included in the survey may become observable at school age as a myopia, amblyopia, or peripheral anomaly of the retina. Furthermore this survey cannot include those cases which had a reversible retrolental fibroplasia that reverted to a normal eye. So we may say that we expect to have over 60 cases of retrolental fibroplasia with severe eye disease in Illinois for 1952. If one may hazard a reasonable guess then one may say that since 1937 when the first case was seen in Chicago 500 to 600 children are partly or totally blind from retrolental fibroplasia in Illinois and more will follow with evidence of the disease.

The survey has also revealed many other problems of interest to public health departments. In this group of prematures there are a large number of children with physical defects which cripple and handicap them.

The intensive effort of Doctor Rawlings and Doctor Sagen, Mrs. Gray, and the excellent cooperation of many physicians have made this progress report on the survey possible. We feel very appreciative for their sustained interest in this project.

The best estimate is that there are over 10,000 children who are partly or totally blind from retrolental fibroplasia in the United States. About 50 per cent of the blindness in children under 7 years of age is caused by this disease. Other countries have a retrolental fibroplasia problems but it is less than ours.

The Relation of Oxygen to the Etiology

Oxygen therapy is definitely related to the production of retrolental fibroplasia. The evidence that this is true is becoming overwhelming.

Before 1935 oxygen therapy was little used in pediatric nurseries. Furthermore the incubators and bassinets were quite open and added oxygen escaped easily. During the past 20 years oxygen and closed incubators came rapidly into use in premature nurseries especially in the well equipped hospitals and medical centers. Furthermore advanced pediatric practice leaned toward oxygen therapy of prematures with respiratory trouble. This explains why the incidence of retrolental fibroplasia is high in prematures and tends to vary with the hospital.

In those hospitals where oxygen therapy for prematures was started a few years ago in England, Canada, and Australia retrolental fibroplasia appeared. When the oxygen therapy was stopped retrolental fibroplasia disappeared. This has been particularly true here and in Great Britain. The British have severely criticized the American practice of giving supplemental oxygen to prematures.

In this country in the pediatric centers after oxygen concentrations were reduced below 40 per cent the incidence of retrolental fibroplasia was markedly decreased. In some centers no retrolental fibroplasia was seen. This drop in incidence has been observed now in a large number of hospitals in Illinois, the United States, and abroad.

At the symposium on retrolental fibroplasia in New York the preliminary report was given on the controlled study sponsored by the National Health Institute and conducted during the past year in 18 hospitals in the United States. It showed that 25 per cent of the infants weighing less than 1,500 gm. at birth had a permanent visual injury from exposure to high oxygen concentration. Only 6 per cent of the premature infants under curtailed oxygen concentrations had permanent damage. High amounts of oxygen given over a short period of time resulted frequently in retinal lesions. The mortality rates of the two groups were insignificant. Thus the clinical evidence leaves no

doubt that excessive oxygen produces retrolental fibroplasia.

The laboratory investigations on oxygen confirms the experience of the clinic. The lesions produced in kittens, puppies, rats, and mice on excessive oxygen are comparable to those occurring in prematures. In England, Ashton observed that oxygen closed or obliterated the growing blood vessels of the retina of the newborn animals. Hemorrhages and retinal detachment followed. By decreasing the oxygen after a short exposure the vessels reopened. Long high concentrations gave irreversible lesions. This experience was confirmed by American and Scandinavian investigators.

The reason why the retinas of early prematures are affected is that the retinal vessels are rapidly forming from optic nerve at this age and are easily damaged by excessive oxygen. The newborn animals have undeveloped retinal vessels in the stage similar to those of the premature infant. When the vessels are well developed as in the full term child they are scarcely affected by the high amounts of oxygen used therapeutically on prematures. Again there seems to be no doubt about the relationship of oxygen to retrolental fibroplasia.

Prevention of Retrolental Fibroplasia

The inquiry is raised whether retrolental fibroplasia can be eliminated entirely. The following comments can be made.

1. With the oxygen concentrations kept below 40 per cent the indications are that only reversible retinal lesions may occur and the severe form is not seen. Minimal vascular lesions may occur in a few infants. In some hospitals no retrolental fibroplasia has been observed since the reduction of oxygen. A 35 per cent concentration of oxygen seems to be the upper limit of safe tolerance.

2. So far as it can be determined in about one out of 1000 cases of severe retrolental fibroplasia, the disease has occurred in infants not exposed to oxygen. This number of cases is insignificant. The disease is rare in full term infants.

3. The question arises whether oxygen therapy affects the survival rate of newborn with anoxia. The controlled study of the 18 hospitals under the National Health Institutes and the National Society of Prevention of Blindness program show that the difference in the survival rate was not significant between the low and high oxygen group. This also has been true in other hospitals with controlled groups of infants with and without oxygen therapy. The answer to this question is that oxygen is rarely the determining factor for survival of the infant.

4. Oxygen therapy still has a place in treatment of anoxia of prematures. The trend of opinion now is against the indiscriminate routine use of oxygen. It is given for cyanosis and respiratory distress and not merely for irregular or periodical respirations. As soon as symptoms are relieved oxygen therapy is discontinued. The New York State Health Department has recommended no routine oxygen therapy for premature babies.

5. If past experience can be applied then oxygen therapy is best given where it is carefully controlled. If the oxygen concentration is 35 per cent it is 75 per cent above normal, if it is 40 per cent it is 100 per cent above normal. There seems to be reasonable maximal concentration at 35 per cent oxygen. High concentrations of oxygen or prolonged exposure immediately after the premature child is born produce the most severe damage to the eye.

Even with the present type of improved incubators and procedures for adding oxygen it is difficult to control the concentration of oxygen. The method of giving a certain number of liters per minute has worked poorly. The use of the oxygen analyzer for the measurement of oxygen gives a better control but it commonly leads to a false sense of security. The best method which requires the least care is the use of cylinders of 35 per cent oxygen and 65 per cent nitrogen. No matter how much gas is used the concentration cannot be over 35 per cent oxygen. This is the procedure that is recommended by those who have applied it here and abroad. There should be no routine oxygen therapy.

From now on anyone who is responsible for oxygen therapy of premature infants must be extremely cautious about the use of oxygen.

Treatment

There is no specific medical treatment for retrolental fibroplasia. Vitamins, roentgen ray, radium, ACTH, and cortisone have no useful effect on the course of the disease. Surgical procedures for glaucoma, and on the membranes and retinal detachment rarely are beneficial. It is not a ques-

tion of treatment and cure but prevention of the disease.

The Future of the Child with Retrolental Fibroplasia

The treatment of a child blind with retrolental fibroplasia does not end with diagnosis. In the early months and years of the life of the child the course of his development and his place in society is determined. The parents need continued help, particularly at this time, on the adjustment of the child to the family and environment. The parents have the heavy responsibility of raising a blind child. If the child is not stimulated and treated as a normal child early in life the damage which is done may be permanent or only partly corrected. There is no need for a child afflicted only with blindness from retrolental fibroplasia to be retarded. Under optimal circumstances the child can grow to an independent adulthood only limited by his innate capabilities.

The way to prevent mental, physical, and social retardation of the child is to use modern information and experience on the growth and development of the blind child in his family and in society. This is done at best by the co-operative counseling and aid from the proper agencies in the community. It begins soon after the diagnosis is made by appropriate consultations with the parents. It continues into the preschool period. The blind child who has been well developed can take his place in the regular nursery school with sighted children because blindness in itself is not the determining factor in the child's development. Failure to provide for the evolution of a healthy personality leads to a gross retardation and the child may end in a state institution. At the state institutions there are 58 children with retrolental fibroplasia if those who died are not included. The Dixon State School, at Dixon, has 13; Lincoln State School, Lincoln, has 11, and Illinois Braille and Sight Saving School, Jacksonville, has 34 from 6 to 12 years old. For 1955 in the Chicago public schools there are 51 blind and 19 partially sighted children with a diagnosis of retrolental fibroplasia.

We are trying in Illinois to have the child become an independent citizen. We know this can be done for most blind children with retrolental fibroplasia. Fortunately in Chicago and Illinois we have three unusual advisory services for blind children. One is the annual Institute for Parents of Preschool Blind Children living in Illinois who are over 3 years of age. Parents who are interested may write for information to: Miss Margaret Kennedy, Division of Child Welfare, 628 East Adams St., Springfield.

The second is a society which is active in retrolental fibroplasia — The Parents of the Blind, Inc. The secretary is: Mrs. Max Guber, 5633 South Drexel Av., Chicago 37.

Third. Miss Norris with her associates of the Preschool Blind Child Project of the University of Chicago has worked closely with the Child Welfare Division of the State of Illinois. For many years several hundred cases of retrolental fibroplasia have been followed almost from birth. Dr. Halstead and this group of investigators will have a book published shortly on what can be done about the children who are blind from retrolental fibroplasia.

Conclusion

The answer to the problem of retrolental fibroplasia at the present time seems to be, first, preventive. I would recommend that, if oxygen therapy is necessary, the oxygen be used from cylinders which contain only 35 per cent oxygen and 65 per cent nitrogen and that oxygen should not be given routinely but only when its use can be justified, Second, I would advise that the parents of the blind infant with retrolental fibroplasia have a complete medical evaluation of the child and the necessary expert guidance for the continuous mental and physical development begun at once.

This is the one disease that began and can be prevented in the short space of half a generation. The wave of maximal incidence has passed. In the future new cases of blindness from retrolental fibroplasia should be a rarity. From now on the extent and depth of the problem of retrolental fibroplasia depends upon us as physicians.

COOK COUNTY HOSPITAL CASE RECORDS

Massive Inversion of the T Wave

Edwin E. Golberg, M.D., Harold B. Shrifter, M.D., and L. Feldman, M.D., F.A.C.P., Chicago

THE rarity of massive T wave inversions has been reported in the literature. At Sea View Hospital, New York, Silverman and Goodman[1] found only one case in 30,000 electrocardiograms. In this case there was an inverted T wave measuring 7 mm. in lead 1 and 14 mm. in lead CF4 with a remarkably prolonged QT interval of 0.66 sec. Ippolito and Blier[2] recently reported three cases of massive T wave inversion. The deepest T wave they recorded was 25 mm. in lead V4. Woods and Wolferth[3] observed an inverted T wave in lead V5 of 19 mm. in a case of myocardial infarction, and an inverted T wave of 13 mm. in lead V5 in a presumably normal college student. Fox, Weaver and March[4] recorded a case of Wolff-Parkinson-White syndrome in which an inverted T wave of 15 mm. in lead III occurred following the intravenous administration of 500 mgm. of Pronestyl (procaine amide).

The following is another case of massive T wave inversion which presents some unique characteristics.

A 70-year old, white, Polish female was admitted to Cook County Hospital on July 26, 1954 with the admitting room diagnosis of a "possible coronary occlusion." The patient was confused, agitated, and disoriented, and because of a language barrier an adequate history was difficult to obtain. She apparently was in good health until a day and a half prior to admission at which time she noticed the sudden onset of "stiffness" in both arms and a "choking" pain in the anterior chest. She was evidently in such respiratory distress that the pulmotor squad of the Fire Department was called to administer oxygen. She also complained of vomiting during this acute episode.

Physical examination revealed a dyspneic, well developed, obese white female. Her temperature was 98.6 degrees F.; respiration, 28 per minute; blood pressure, systolic 154 and diastolic 80. The apical rate was 100 and irregularly irregular, with no pulse deficit. There were bilateral cataracts and the fundi could not be visualized. The neck was tender to palpation with minimal venous distention. The chest was barrel shaped, and the breath sounds were markedly diminished with crepitant rales in both bases. Percussion of the heart was inadequate because of emphysema. P2 was equal to A2. The tones were distant at the base. There was a soft systolic murmur, grade 1, at the apex. The liver was palpable one to two finger-breadths below the costal margin and tender. There was one plus pitting edema of the ankles. Pulsations of the dorsal pedis arteries were present bilaterally. The deep tendon reflexes were hypoactive.

Admission urine was normal with a specific gravity of 1:020 with two to three white blood cells and three to four red blood cells per high

From the Department of Internal Medicine, Cook County Hospital, and the University of Illinois College of Medicine, Chicago, Illinois.

power field in the sediment. Examination of the blood revealed a hemoglobin of 75 per cent; red blood cells, 4.56 million per cubic mm.; white blood cells, 8,500 per cubic mm.; with a normal differential count. The platelets were adequate in number. The erythrocyte sedimentation rate was 23 mm. per hour and hematocrit 43 per cent. Repeat white blood cell count four days later was 11,000 per cubic mm. Serology was negative. The blood chemistries on admission were as follows: non-protein nitrogen, 36 mg. per cent; total protein, 6.6 grams per cent; serum chlorides, 98 meq. per liter; serum sodium, 128 meq. per liter; serum potassium, 3.7 meq. per liter; and, total cholesterol 200 mg. per cent.

Roentgenogram of the chest revealed the transverse cardiac diameter to be increased with prominence of the left ventricular segment. Calcifications were noted within the descending arch of the aorta. The lung fields revealed some increase in bronchovascular markings. At this time the electrocardiogram (Figure 1) revealed a left axis shift and flutter-fibrillation with a ventricular response of 120. There were deep T wave inversions in leads I, II, AVL, V2, V3, V4, V5, and V6, with the greatest negativity present in V4 and measuring 21 mm.

The patient was placed on a low salt diet, digitalized, and given intramuscular mercuhydrin and she improved. From the third to the sixth hospital day, her temperature ranged from 100.2 degrees to 100.8 degrees F., finally returning to normal on intramuscular penicillin, 600,000 units daily. She continued to do well until her 12th hospital day, when she complained of sudden pain in the right foot and leg. At this time the right foot and leg were noted to be cold and blanched, and pulsations were totally absent below the popliteal artery. Lumbar sympathetic blocks were performed, and papaverine [grains one and a half, three times daily] was given but with little response. Anticoagulants were started but from this point the patient's course rapidly went downhill and she expired 30 days after her admission to the hospital. No autopsy was allowed. Five days prior to death an electrocardiogram (Figure 2) revealed a left axis shift, digitalis effect, and flutter-fibrillation with a ventricular response of 110. The T waves inverted in leads I, II, III, VI, V2, V3, V4, V5, V6 and in AVF, but did not show the massive T wave inversions that were seen in Figure 1.

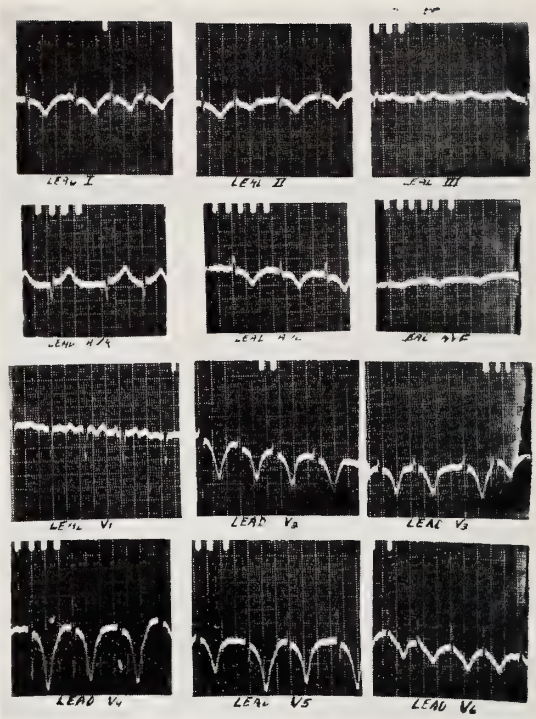


Figure 1. Electrocardiogram taken on July 26, 1954 (on admission) showing flutter-fibrillation and massive T wave inversion.

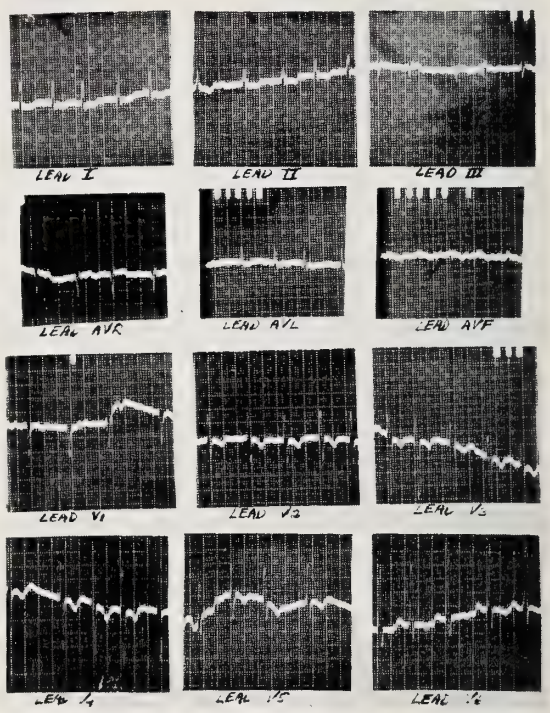


Figure 2. Electrocardiogram taken on August 20, 1954 (five days before death) showing flutter-fibrillation with reversion of T waves to the usual pattern of myocardial ischemia.

The past history revealed that the patient had been hospitalized five years ago at which time her main complaints were shortness of breath, ankle edema, and paroxysmal nocturnal dyspnea of six months' duration. Physical examination at that time revealed a dyspneic, white female. Her blood pressure was 164 systolic, and 112 diastolic. The pulse and apical rates were 92 and irregularly irregular. On percussion the heart was enlarged to the left with a hypertensive contour. The lungs showed bilateral basal congestion; there was venous distension of the neck, and the liver was three finger-breadths below the costal margin and tender. There was two plus pedal edema. The electrocardiogram (Figure 3) revealed left axis shift and a flutter-fibrillation with a ventricular response of 72. She was placed on a low salt diet, given mercurhydrin, and digitalized. After eight days she was discharged from the hospital fully compensated, with a diagnosis of hypertensive heart disease in failure. The patient was seen periodically as an out-patient in our cardiac clinic and remained adequately compensated and in good electrolyte balance until her present admission.

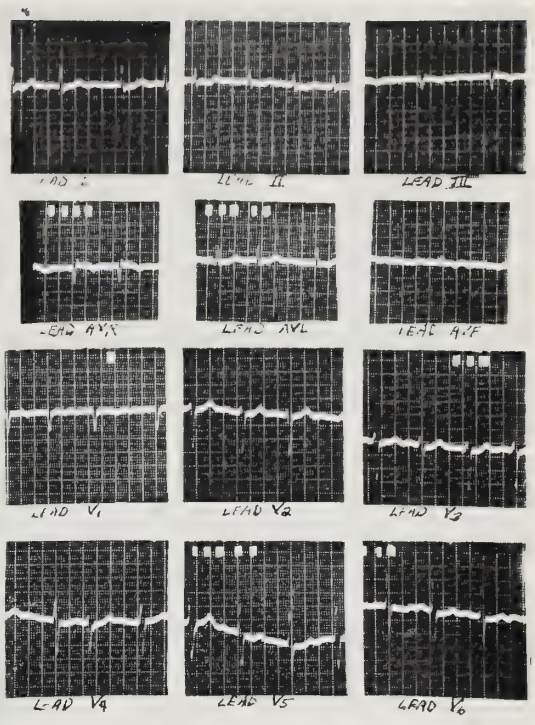


Figure 3. Electrocardiogram taken March 5, 1949 (five years before present hospital admission) showing flutter-fibrillation.

Discussion

T wave inversions are one of the most common abnormalities found in electrocardiography. Unlike the QRS complex, the duration, direction, and contour of the T wave is markedly influenced by factors changing its rate of spread, or its time of onset in relation to the polarity and activity of the surrounding areas of myocardium. In addition, it has been shown that most of the conditions which cause an alteration of the recovery process are confined to localized areas of heart muscle and do not usually affect the myocardium as a whole.[5]

Thus, abnormal T waves can be seen in a large number of conditions in which there is a change — either physiological or pathological or both — in repolarization of the ventricle. Such changes are commonly seen in the following conditions:

1) Myocardial ischemia either absolute or relative:
(a) emotion
(b) overactivity of the heart
(c) smoking
(d) ingestion of cold water
(e) reflex
2) Position of the heart
3) Inflammation:
(a) pericarditis
(b) myocarditis
4) Injury
5) Drugs:
(a) digitalis
(b) quinidine
(c) pronestyl
6) Electrolyte imbalance:
(a) hypopotassemia
(b) hypocalcemia
7) Non-specific

Massive T wave inversions have been reported in three of the above conditions.

A. Myocardial ischemia[1,2]

B. Therapy with pronestyl[4]

C. Non-specific (normal college student[3].

Ippolito and Blier[2] in a recent review of massive T wave inversions, state that coronary insufficiency and a slow ventricular rate are prerequisites for the occurrence of this phenomenon and that such cases are associated with prolongation of the QT interval. They remark further that "if the slow ventricular rate and the presence of coronary insufficiency are etiologically related, then the following may perhaps be stated

with hesitation. The repolarization of a locally damaged heart may be delayed if the intraventricular volume is increased (prolonged diastole) and intraventricular pressure built up."

The presence of a slow ventricular response in all the reported cases to date has prompted Ippolito and Blier to the conclusion that the vagus may play some role in the mechanism of massive T wave inversion.

The actual size of the inverted T wave is difficult to explain with certainty, but is apparently related to the volume of ischemic myocardium[6]. Changes in the serum electrolytes[8], particularly potassium, may influence inversion of the T waves. The area of the QRS is also related to the extent of the inversion of the T wave[4].

Our case manifests neither bradycardia nor exceptional prolongation of the QT interval. Indeed, the case we are reporting shows a rather rapid ventricular response in auricular fibrillation, with massive T wave inversion, to the extent of a 21 mm. inverted T wave in lead V4. This is most unusual, for it has been shown that the negativity of the T wave in cases of auricular fibrillation and flutter is increased if the preceding diastole is lengthened[8]. Our patient undoubtedly had myocardial ischemia as evidenced by her persistently abnormal T wave changes while in the hospital. It is interesting to observe that the massive T wave inversions persisted for only a short period and then reverted to the more usual T wave changes seen in myocardial ischemia. The lability of massive T wave inversions is evidently not uncommon and is probably related in part to the degree and time period of ischemia.

So far as we can determine, the predominant cause of massive T wave inversion in the case we are reporting is myocardial ischemia; for it is apparent that neither slow ventricular response nor vagal influences could account for our patient's abnormal electrocardiograms. We do not think that the volume of the QRS were responsible for these changes, as the T wave inversions were seen to extend to the epicardial surface of the right ventricle and there is no evidence of right ventricular hypertrophy.

Summary

The literature on massive T wave inversion is reviewed and a case is reported which did not show bradycardia. This had previously been thought to be one of the main charcteristics of massive T wave inversion. Evidently the only factor required to cause this abnormality is myocardial insufficiency.

REFERENCES

1. Silverman, J. J. and Goodman, R. D. II: Massive T wave inversion with recovery. The Quart. Bull. Sea View Hospital. **11**:72-79, April, 1949.
2. Ippolito, T. L., Blier, J. S. and Fox, T. T.: Massive T wave inversion. Am. Heart J. **48**:82-94, July, 1954.
3. Woods, F. C. and Wolferth, C. C.: Huge T waves in precordial leads in cardiac infarction. Am. Heart J. **9**:706-721, August, 1934.
4. Fox, T. T., Weaver, J. and March, H. W.: On the mechanism of the arrhythmias in aberrant atruventricular enduction. Am. Heart J. **43**:507-520, April, 1952.
5. Barker, J. N.: The Unipolar Electrocardiogram. Appleton-Century-Crofts, New York, 1952.
6. Bayley, R. H.: An interpretation of the injury and the ischemia effects of myocardial infarction in accordance with the laws which determine the flow of electrical currents in homogenous volume conductors, and in accordance with relevant pathologic changes. Am. Heart J. **24**:514-528, October, 1942.
7. Sharpey-Shafer, E. P.: Potassium effects in T-wave inversion in myocardial infarction and preponderance of a ventricle. Brit. Heart J. **5**:80-84, April, 1943.
8. Scherf, D. and Blumenfeld, S.: Variations of form of T waves in auricular flutter and auricular fibrillation, associated with changes of rate Am. Heart J. **46**:543-556, October, 1953.

PATHOLOGY CONFERENCES

Edwin F. Hirsch, Department Editor

1. Friedreich's ataxia complicated by chronic fibroplastic myocarditis.
2. Perforation of a peptic ulcer of the stomach and sudden death.

EDWIN F. HIRSCH, M.D., CHICAGO

Case 1. Friedreich's ataxia complicated by chronic fibroplastic myocarditis.

A young white woman, aged 16 years, entered St. Luke's Hospital in the care of Doctor Roland P. Mackay on December 7, 1953 and died on the 15th. She had had spasticity of the legs with positive Babinski reflexes since the age of seven years. She attended school and walked until the summer of 1953. At that time she gained considerable weight and tired easily with moderate exercise. For about ten days before entering the hospital she felt weak, did not attend school, and then was observed to lift her legs with her hands while walking. She spoke very little and only with much effort. Two days before admission she became paraplegic and her state of consciousness decreased.

When examined at the hospital, the pupils reacted to light but not to accommodation. There was no nystagmus. Her temperature was 100.2° F., the pulse was 120 and the respirations were 22 per minute. The blood pressure was 100/? mms. Hg.; the heart had a sinus tachycardia, the tones were strong and without murmurs; the legs had a slight pitting edema. The lower extremities were paraplegic and in spastic contraction, the arms had almost normal strength. The knee jerks were present with reenforcement, the arm jerks were absent. The Babinski reflexes were strongly positive on both sides. The neck was rigid. Sensory tests were not done.

The blood had 4,500,000 erythrocytes and 14,800 leukocytes per cubic mm. and 13.8 gms. percent hemoglobin. The non-protein nitrogen of the blood was 48 mgms., the sugar 119 mgms. percent. The spinal fluid had 26 mgms. percent protein. The urine contained considerable albumin, a few erythrocytes and leukocytes. Roentgen films of the chest and cervical spine disclosed nothing unusual. An electrocardiogram had sinus tachycardia and abnormal features resembling those of rheumatic heart disease.

On December 9th the patient was lethargic, her temperature was 103.4°F. and the fever persisted despite antibiotics. The spinal fluid on December 14th had an initial pressure of 180 mms. of water, and a closing pressure of 150; it contained a few erythrocytes and 22 mgms. percent protein; the Pandy was negative, the colloidal gold curve was 111 000 000. The face

From the Henry Baird Favill Laboratory of St. Luke's Hospital, Chicago.

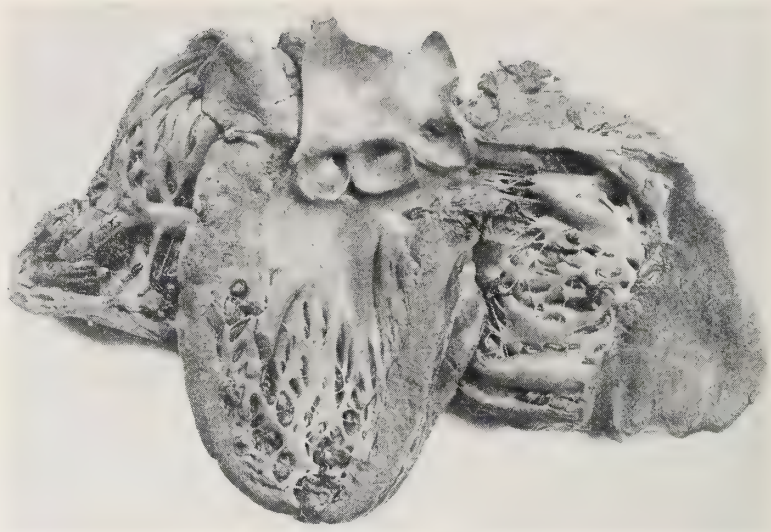


Figure 1. Photograph illustrating the multiple mural thrombi on the lining of the left ventricle of the heart with chronic fibroplastic myocarditis.

and legs were edematous. Death occurred on December 15, 1953.

The significant portions of the anatomic diagnosis of the complete necropsy are:

Chronic fibrous myocarditis;
multiple mural thrombi of the lining of the left ventricle of the heart;
Dilated chambers of the heart;
Anasarca, ascites and bilateral hydrothorax;
Hyperemia and edema of the lungs;
Chronic passive hyperemia of the liver and spleen; etc.

The body of this young woman weighed 100 pounds and was 156 cms. long. There was a marked generalized edema, especially of the lower extremities. The abdomen contained 250 cc. of a clear yellow fluid, each pleural space 300 cc. The edematous and hyperemic right lung weighed 540 gms., the left 470 gms. The heart weighed 310 gms. The pulmonic and tricuspid valves had no significant changes. The chamber of the left ventricle was dilated and between the columnae carneae in the lining of the lateral wall were several adherent gray red thrombi ranging to 6-8 mms. diameter. More of these were on the septal endocardium (Figure 1). The leaflets of the mitral and aortic valves had no significant changes. The coronary arteries had a smooth lining. The myocardium of the lateral wall of the left ventricle and of the septum had brown fibrillar tissues mottled with gray scars.

The right kidney weighed 130 gms., the left 140 gms.; the liver weighed 940 gms., the spleen 100 gms. These viscera had the changes of a chronic passive hyperemia. The tissues of the gastro-intestinal tract and other viscera of the trunk, the structures of the pelvis, and of the neck had nothing significant.

The brain with the upper half of the dura weighed 1040 gms. The spinal fluid was clear, the leptomeninges were thin, the cerebral and cerebellar hemispheres were symmetrical. There were no gross lesions. The entire spinal cord was removed. The dural and cranial sinuses, both middle ears and the hypophysis had no significant changes. Histological examination of the heart muscle demonstrated a diffuse growth of fibrous tissue in the myocardium with replacement and marked atrophy of the muscle fibers. Exudate cells in these tissues were minimal in amount.

After fixation in a solution of formaldehyde further gross and microscopic examinations of the brain and spinal cord were made. Gross sections of the brain, the pons, and the upper portion of the spinal cord, and of the spinal cord itself afforded no diagnostic information. Sections of the brain and those from many levels of the spinal cord were stained by seven specific methods. In the lumbar region, the posterior and lateral columns of the spinal cord had degenerative changes such as occur with a Friedreich's ataxia syndrome.

COMMENT

The Friedreich's ataxia syndrome of this young woman extending from early youth, became complicated by a chronic progressive fibroplastic myocarditis, which was the more seri-

ous life hazard. The Friedreich's ataxia is considered to have a familial causal factor, the chronic myocarditis an infectious. This form of myocarditis is an insidious disease, occurs commonly in young adults, and seems to be a chronic progressive cardiac disorder.

Case 2. Perforation of a peptic ulcer of the stomach and sudden death.

A negress aged 53 years entered St. Luke's Hospital in the care of Doctor H. I. Meyer at 10:15 A.M. on December 18, 1953 and died seven hours and 15 minutes later. Eight years before, she was told that she had a high blood pressure. For five months she had epigastric pain 1 to 2 hours after each meal, and for a week this discomfort had been constant. While in the examining room during the time her blood pressure was being measured, she had an acute attack of epigastric pain. Her temperature was 98.6°F., the pulse was 114 and the respirations were 20 per minute. The blood had 5,000,000 erythrocytes and 6,200 leukocytes per c.mm. and 14.6 gms. percent hemoglobin. The straw colored urine had a pH of 7.5 and contained 40 mgms. percent albumin. At 12:30 her blood pressure was 65/0 mms. Hg., the heart rate was 160 per minute with marked compensatory pauses. The pulse deficit at times was 1:3. Bowel sounds were practically absent, and the abdominal tenderness seemed greater in the lower quadrants. At 3:00 P.M. brown fluids were aspirated from the stomach and contained occult blood. An electrocardiogram had occasional premature systoles. The patient did not recover from shock, constantly complained of abdominal pain and died. Myocardial infarction was considered to be the cause of death.

The significant parts of the anatomic diagnosis of the complete necropsy are: Perforated chronic peptic ulcer of the pylorus of the stomach; Generalized acute serofibrinous peritonitis; Marked muscular hypertrophy and dilatation of the lumen of the stomach; etc.

The body of this negress weighed 180 pounds and was 172 cms. long. The abdomen contained 2500 cc. of dark brown fluid, and everywhere the peritoneum was markedly hyperemic and



Figure 2. Photograph illustrating the perforated peptic ulcer in the anterior wall of the pylorus of the stomach.

covered with membranous plaques of fibrin. The front wall of the stomach near the pyloric sphincter and toward the lesser curvature had a round perforation 1 cm. in diam. (Figure 2) and on the mucosal surface opposite was a peptic ulcer 1.4 cms. in diam. The hugely dilated stomach contained a large amount of brown fluid and the opening of the pylorus into the duodenum was narrowed to an inside diam. of 1.8 cms. The routine examination of the heart, lungs, liver, kidneys, spleen and other viscera of the trunk, the neck and the head disclosed only changes associated with ageing of the tissues. Histological preparations through several levels of the ulcer demonstrated necrosis and inflammatory tissues, but none cancerous.

COMMENT

This acute episode of perforation of a peptic ulcer of the stomach with the escape into the peritoneum of large amounts of gastric fluid and the associated profound clinical shock in a patient practically under medical observation throughout, illustrate the seriousness of perforation of a gastric ulcer. The clinical manifestations and the rapidity with which death occurred suggested even cardiac infarction. The necropsy disclosed the cause of the confusing symptoms.

EDITORIALS

C-reactive protein

The presence or absence of C-reactive protein in serum is becoming a popular test for a variety of infections, including rheumatic fever. In this respect, it shares a place with the white blood count and sedimentation rate in diagnosis.

Tillett and Francis observed that the serum of patients with lobar pneumonia precipitated when mixed with a solution of p-saccharide of pneumococcus. The precipitate was positive during the acute stage but disappeared after the crisis.

Initially, the active substance was regarded as a specific antibody to the pneumococcus but subsequent study demonstrated that the reaction was not limited to pneumococcal disorders; it took place also during the acute phase of streptococcal and staphylococcal infections and of rheumatic fever.

Because the test (C.R.P.) is a sensitive indicator of rheumatic activity, it is useful in the management of the rheumatic fever patient. The result is positive during the active stage and may become negative before the sedimentation rate returns to normal.

Its relationship to treatment is interesting. During treatment with cortisone or related steroid, the C. R. P. becomes negative if a good response takes place. Failure to obtain this response is a sign that the dosage is not large enough to suppress rheumatic activity.

After the medication is discontinued the C-reactive protein appears in the serum if there is a remission of the disease. There is no reversal of the reaction with aspirin until the clinical manifestations of the disease subside.

But a low grade rheumatic process is not strong enough to make C-reactive proteins form. This explains why the test is negative in chorea, erythema marginatum, and subcutaneous nodules. It usually is negative in other collagen diseases including disseminated lupus erythematosis, dermatomyositis, and scleroderma. The same applies to viral hepatitis. In this respect, it is of more value when positive than when negative.

A positive reaction generally occurs during the inflammatory phase of gout and rheumatoid arthritis; it is negative during the afebrile stages. C. R. P. also appear during the early stages of a mild upper respiratory infection but disappear promptly at the end of the cold. If the reaction persists, there is a possibility of rheumatic fever.

The following experiment demonstrated this point: When serum was obtained from a group of hemolytic strep infections, the test was positive in 57 per cent of patients who did not develop complications; in 75 per cent of those with purulent complications; and in 97 per cent of those who developed rheumatic fever.

The C-reactive protein test also is of value in acute myocardial infarction. It is negative in patients with angina pectoris but becomes positive within 36 hours after an attack of coronary occlusion. Following commissurotomy for rheumatic mitral stenosis, the test became positive in eight out of 13 patients and remained so for eight weeks.

Pathologic diagnostic service

For several years the Bureau of Cancer Control of the Illinois Department of Public Health has financially supported a pathologic diagnostic service. The program provides facilities for physicians and dentists whereby they may submit biopsy specimens for examinations without cost, from patients who cannot afford to pay for such service and in whom a malignant condition is suspected. Containers and request forms for the submission of such specimens may be obtained by writing the Bureau of Cancer Control, Illinois Department of Public Health, Springfield, Illinois. In order that the patient not be charged for the service it is important that the physician sign his name to the certification on the request form where it states that the person cannot afford to pay.

Biopsy specimens for standard tissue examination may be mailed or brought to the State-supported cancer clinics in the following locations, where they will be processed by the pathologist of the respective clinic.

BLOOMINGTON,
Mennonite Hospital (c)
CANTON,
Graham Hospital (c)
CARBONDALE,
Doctors Hospital (c)
CENTRALIA,
St. Mary's Hospital (c)
CHAMPAIGN,
Burnham City Hospital (c)
DANVILLE,
St. Elizabeth's Hospital (c)
DuQUOIN,
Marshall Browning Hospital
EAST ST. LOUIS,
Christian Welfare Hospital (c)
ELGIN,
Sherman Hospital (c)
EVANSTON,
Evanston Hospital (c)
St. Francis Hospital (c)
EVERGREEN PARK,
Little Company of Mary Hospital (c)
FAIRFIELD,
Fairfield Memorial Hospital (c)
HERRIN,
Herrin Hospital (c)
HILLSBORO,
Hillsboro Hospital (c)
JACKSONVILLE,
Passavant Memorial Hospital (c)
JOLIET,
St. Joseph's Hospital (c)
MATTOON,
Memorial Hospital
MT. VERNON,
Mt. Vernon State Tuberculosis San.
OTTAWA,
Ryburn Memorial Hospital (c)
PEORIA,
Methodist Hospital (c)
ROCKFORD,
St. Anthony's Hospital (c)
SAVANNA,
Savanna City Hospital (c)
SPRINGFIELD,
Memorial Hospital (c)
WAUKEGAN,
Victory Memorial Hospital (c)

A cytology diagnostic service for patients who cannot afford to pay is being supported by us in a small way because of budget limitations, and *is not on a mailing basis.* Any physician who has such a patient and wishes this type of examination may obtain it without cost to the patient by referring the patient to the cancer clinics listed above marked (c) where the pathologists have indicated that they would be able to provide this service. Here again the referring physician must certify that the patient cannot afford to pay in order that no charge be made.

‹ ›

A.M.A. study conference

A study conference called by the American Medical Association to consider methods of informing its membership of certain aspects of pending legislation was held in Chicago, October 22. More than 100 representatives of constituent state medical associations, AMA officers, and members of the Board of Trustees participated in discussions and considered approaches for focusing the public's attention upon the AMA's viewpoint.

H. R. 7225, known as the Social Security Amendments of 1955, includes provision for the payment of monthly cash benefits to the permanently and totally disabled at age 50. The bill, passed by the House of Representatives last

summer, will come before the Senate Finance Committee for public hearings early in the next session of Congress.

Comments of participants were solicited at the Chicago meeting and AMA officers, and trustees are currently studying these opinions. Dr. George F. Lull, AMA Secretary and General Manager, urged that all medical society representatives who attended the conference send further comments, suggestions or criticisms to AMA headquarters. He pointed out that the Association is studying the consensus of the state representatives who attended the conference and will proceed in a manner consistent with the views of the majority.

Giving the official address of welcome at the conference, Dr. Gunnar Gundersen, chairman of the Board of Trustees, said:

"Our great aim should be to join with other groups and organizations, with the press and other communications media, and with responsible leaders of both political parties to separate Social Security and politics. The AMA believes that problems of Social Security should be solved on the basis of sound judgment, an objective analysis of facts, a humane attitude toward human suffering—and not on the basis of political expediency."

Dr. Elmer Hess, AMA president, emphasized that the program to promote a better Social Security system must be considered a "long range effort," looking forward to 1958, 1960, even to 1962. He also stressed that study of social security legislation will require close co-operation and mutual activity at the national and local levels.

‹ ›

New honors for Dr. Telford

Two days after the announcement that Dr. Elbridge W. Telford of DeKalb had been selected by the Illinois State Medical Society as the "General Practitioner for 1956" he was informed that he was the recipient of one of the highest honors to be granted by the Korean Government.

Dr. Telford was awarded the Korean Distinguished Military Service Medal for his work in setting up an efficient medical department among Korean troops while serving as division surgeon of the 45th United States Division.

This honor followed two previous high ones—the United States Bronze Medal and the Philippine Legion of Honor—for his Korean services.



Elbridge W. Telford, M.D.

Dr. Telford has a distinguished military record. While attending Northwestern University Medical School, he served in the Illinois National Guard and was on active duty on numerous occasions. After entering practice in 1928, he became a member of the Officers' Reserve Corps.

At the first sign of war clouds in 1941, he joined the 33rd Division as a first lieutenant in the Medical Corps. He served in the Pacific Theater and then was assigned to accompany Gen. Patton's 3rd Army across Europe. His hospital unit had one of the smallest mortality rates in the war. He was released in 1945 as a major.

In 1947, Dr. Telford helped to organize the medical staff of the 44th Division. With the outbreak of the Korean war, he was assigned to that unit as division surgeon and lieutenant colonel.

Due to the need for medical personnel in Korea, he was sent on ahead to become the division surgeon of the 45th Division, then already in action. Ten of his 14½ months in Korea were spent in combat areas.

Besides organizing one of the best medical units among any United States division, he helped to establish efficient medical organizations among Korean and Philippine troops.

The Illinois State Medical Society's citation will be presented to Dr. Telford at the annual meeting of the Society in May. Fifty-four years old, he is one of the youngest of the eight physicians to receive this award of colleagues. He has an outstanding record as a general practitioner in De Kalb in the intervals when he was not serving his country in foreign lands.

‹ ›

Governor vetoes proposed revision (Senate Bill 247) of the Coroners Act of 1874

Senate Bills 247 and 248 introduced by Senator Albert Scott of Canton and offering revisions of the archaic Coroner's Act of 1874, passed the Senate by a vote of 29 to 5, and on the final day of the last General Assembly, June 30, 1955 were voted through the House of Representatives 94 to 7 and 94 to 6, respectively. Members of the Illinois State Medical Society, representatives of the Illinois Coroners Association, and advisors from the Illinois Department of Public Health had met in preliminary discussions and joined their conclusions in the final draft of these bills.

Senate Bill 247 defined more clearly the cases of death that belong to the jurisdiction of the Coroner; it specified coroner's juries only for cases of suicide, homicide, and accidental death; and it provided that the medical examinations be made by physicians licensed to practice medicine in all of its branches, and wherever possible with special training in pathology. It did not require that these physicians be certified pathologists.

Senate Bill 248, a companion to Senate Bill 247, afforded assistance to the coroner of each down-state county in securing a qualified physician to make the medical examination of his cases. It did so by arranging for these appointments through the Director of the State Public Health Department in consultation with the elected Coroner of a down-state county. Coroners and the Director of Public Health, in this plan, could thus cooperate in improving the medical examinations of coroner cases through the State, and groups of counties would benefit where each alone could have difficulty to obtain a qualified examiner. Senate Bill 248 further included the appointment of an Advisory Board by the Governor to advise the Director of Public Health and the coroners of the counties in the development and improvement of this service. This Advisory Board of nine members was constituted to include three physicians, three elected coroners, and three laymen acquainted with the problems of forensic medicine.

Governor Stratton on July 7th signed S. B. 248, but later vetoed S. B. 247. The Illinois State Medical Society, other Medical organizations and lay groups were disappointed with his veto. This veto was on the basis that "a number of pathologists who would not ordinarily be employed by the coroners would be placed on county payrolls by appointment through one of the State departments. The result would be effectively to destroy county control over the cost and expense of the coroner's office." This interpretation, however, is not in full agreement with the specific directives covering the qualifications and appointment of coroner's physicians in S. B. 247. The details of this agreement are mentioned in the appended answer to the governor's friendly letter containing his veto message.

After Senate Bills 247 and 248 had been approved by the General Assembly, the following three letters were exchanged in correspondence with Governor William G. Stratton:

JULY 1, 1955

Honorable William G. Stratton,
Governor of the State of Illinois,
Springfield, Illinois.
Dear Sir:

On behalf of the Illinois State Medical Society I am writing this letter to urge that you give favorable consideration and approval to Senate Bills 247 and 248. These Bills were passed by the House of Representatives on June 30th, and have been sent to your office. The Bills propose a much needed revision of the Coroner's Act of 1874, since when no sections of consequence have been added to the Statutes.

Senate Bill 247 defines more clearly the cases of death that belong to the jurisdiction of the Coroner; saves money for Counties by requiring coroner's juries only in cases of suicide, homicide or accidental death; improves the quality of postmortem examinations throughout downstate Illinois by using doctors trained for this work.

Senate Bill 248 enables the Illinois Department of Public Health to assist Coroners in the

conduct of their investigations and provides an Advisory Board appointed by the Governor to advise upon and improve the quality of these services. The Advisory Board can suggest to the Department of Public Health procedures for the correction or adjustment of difficulties that opponents of these Bills have mentioned. Counties with adequate facilities are not affected by these Bills, except that opportunity for improvements are offered.

The members of the Illinois State Medical Society believes that Senate Bills 247 and 248 contain some of the most significant legislation in medicine and community health that has happened in Illinois. They urge your careful consideration and endorsement of these Bills.

Sincerely yours,

/s/

Edwin F. Hirsch, M. D.
Chairman of the Committee on Revision of the Coroner's Act, Illinois State Medical Society

August 8, 1955

Dr. Edwin F. Hirsch
Illinois State Medical Society
1439 South Michigan Avenue
Chicago, Illinois

Dear Doctor Hirsch:

Thank you for your letter relative to Senate Bills 247 and 248. As you undoubtedly know, I approved No. 248 on July 7, 1955. However, I found it necessary to veto No. 247. The enclosed copy of my veto message explains my reasons for doing so.

With appreciation for your interest and kind regards.

Sincerely yours,

/s/

William G. Stratton
Governor

WGS:ms
Enclosure

August 12, 1955

The Honorable William G. Stratton,
Governor of Illinois,
State Capitol Building,
Springfield, Illinois.

Dear Governor Stratton:

Thanks kindly for your letter of the 8th inst. relative to Senate Bills 247 and 248. The Illinois State Medical Society is pleased indeed that you approved Bill 248 on July 7, 1955. At the meeting of the Council of the Illinois State Medical Society on Sunday, August 7 at the Sherman Hotel in Chicago all of the members voiced a feeling of regret that you deemed advisable a veto of Bill No. 247. A similar feeling had been expressed on an earlier date at a meeting of the Board of Governors of the Institute of Medicine of Chicago. These expressions of feelings occurred because so much potential good of Senate Bill 247 had been lost on the basis of certain possible hazards which the drafting groups had considered but which no one believed would constitute a serious obstacle.

Your veto message stated in part:

"This Bill involves a fundamental change in the powers of the Coroners. The result will be to place upon the county payroll by appointment through one of the State Departments a number of pathologists who would not ordinarily be employed by the coroners. The result would be effectively to destroy county control over the cost and expense of the Coroner's office. Because of the fundamental departure from the existing law, this subject demands further consideration by the General Assembly."

It is fair to say that all of the provisions contained in both Bills 247 and 248 came as the result of discussions and pooled experiences of representatives of the Illinois State Medical Society, of the Illinois Coroners Association and of the Illinois Department of Public Health. All groups realized the presence of great defects in the present Coroner's Act which dates back to 1874, and especially in the quality of the medical examinations of coroner cases which everyone, lay and professional, agrees is in the field of medicine.

In order to help the Coroners of the many counties of Illinois in this respect, and to enable all downstate counties to have at least some of this professional benefit, only the minimum requirement for professional skill in necropsy examinations was specified with the hope that a modest beginning would initiate a growing service which in time the State of Illinois could look upon with respect and pride.

The specifications for the Coroner's physician performing these functions as set forth in Sec.

10.1 on page 4 of Senate Bill 247 read as follows:

"Any medical examination or autopsy conducted pursuant to this Act shall be performed by a physician duly licensed to practice medicine in all of its branches and *wherever possible* by one having special training in pathology. In Class I counties (Cook) such medical examinations or autopsies shall be performed by physicians appointed or designated by the coroner and in Class II counties (downstate) by physicians appointed or designated by the director of the Department of Public Health," and in amendment 4, "In making such appointments or designations the director of the Department of Public Health *shall consult with the elected coroner in each county.*"

None of these provisions orders the use of pathologists as specialists for the necropsy examinations. They only say that wherever possible, physicians with special training in pathology be used, and state clearly that these appointments or designations of physicians to make the necropsy examination be through the Director of Public Health in *consultation with* the elected coroner in each county. The purpose of this plan was to use well qualified physicians for groups of counties where individual coroners might have difficulty in obtaining this service.

When the Coroner's Act was placed on the statutes in 1874 modern scientific aids in the detection of the cause of unnatural deaths had not been developed. The Institute of Medicine of Chicago for more than 25 years has urged legislative improvement of the old Coroner's Act of 1874, and in this effort more recently was joined by the Chicago Medical Society, the Illinois State Medical Society, the Illinois Coroners Association, Welfare Council of Metropolitan Chicago, and other civic organizations.

Inasmuch as you have signed Senate Bill 248 which provides for the appointment of an Advisory Board on Necropsy Service to Coroners in the Department of Public Health, the Illinois State Medical Society and other interested groups earnestly hope that you will appoint soon the members of this Board. This Advisory Board can then investigate thoroughly and make suitable proposals to clarify phases of this service that now seem in doubt. You will receive presently suggestions as to qualified physicians for appointment to this Board from the Chairman of the Council of the Illinois State Medical Society through the Director of the Department of Public Health. The Illinois Coroners Association also is expected to submit suggestions for your consideration.

An Advisory Board composed of physicians, coroners and lay members, working together, can help realize great improvements in the administration of criminal and social justice in the State of Illinois.

May I thank you again for your kind letter.

Sincerely yours,

/s/

Edwin F. Hirsch, M. D.
Illinois State Medical Society

The comments and the three letters are a statement to the members of the Illinois State Medical Society from the Committee on Revision of the Coroner's Act. The Committee hopes that Governor Stratton will appoint promptly the Advisory Board authorized under the provisions of Senate Bill 248, and that this Board will investigate and clarify questions that can make possible proposals of legislation even better than those contained in Senate Bill 247.

‹ ›

Compensating the faculties of medicine

Many medical school professors hold a unique position in our educational system. They are paid for teaching and research but, unlike their academic colleagues in the Latin and Greek departments, usually work for their salaries by rendering medical service to patients in the school hospital or clinic. The institution collects the money and now and then there is enough left over to subsidize the classical language department.

It is an unusual situation. Men who teach agriculture are not required to operate a farm to make a living and the same can be said of instructors in banking and insurance. There is no objective to this system if the physician realizes he is being exploited. Nor does organized medicine object provided every cent goes back to the practicing physician after deductions have been made for expenses.

One of the basic reasons for these differences is the wide variance in compensation in the teaching and the practice of medicine. There are as many plans for compensating the faculty of

clinical departments as there are medical schools. The majority are geared to suit the individual school and community.

There is some friction between the medical faculty and the local medical society. This is explained by the fact that to attract physicians, the medical school is forced to make unusual concessions which become targets for criticism. For example, the medical society objects when an instructor is permitted to care for private patients in the university or state hospital. In these instances, the system rather than the physician ought to be blamed.

‹ ›

Richard J. Graff, M.D. received citizens' award

Dr. Richard J. Graff, superintendent of Manteno State Hospital, received an award commemorating his 25 years of service in the care of the mentally ill. This award was given on October 22 at the Manteno Hospital, Illinois, largest mental hospital. Although the oldest mental hospital superintendent in terms of state service, Dr. Graff is only 53 years of age. The presentation was in the form of a silver plaque. Dr. Graff, long a member of the Illinois State Medical Society, began his work in mental institutions at the Dixon State Hospital.

In 1941 he became superintendent of Lincoln State School. He left Lincoln in 1942 to enter the Medical Corps of the United States Air Force, serving two years in this country then two years in the European theater of operation. He was discharged in 1946 with the rank of colonel, then became superintendent of Peoria State Hospital. In 1949 be became the first superintendent of the Galesburg State Research Hospital where he remained until June, 1954, when he was transferred to Manteno State Hospital as its superintendent.

While in Galesburg, he became secretary of the Knox County Medical Society and was quite active in the affairs of that society. Dr. Graff has made many contributions to psychiatry, and in addition to a fellowship in the American Psychiatric Association, he is a member of several other special societies.

Those of us who have known Dr. Graff during these many years of faithful service in mental hospitals in Illinois, offer our congratulations and best wishes for his meritorious service.

‹ ›

Medicine on postage stamps

Among recent issues of postage stamps were the following which are of interest to physician philatelists:

Netherlands—five special stamps, each with a surcharge to help in the fight against cancer. The design shows a microscope and crab.

Australia—A 3½d stamp in honor of the nursing profession. Florence Nightingale is a background figure.

Italy—International Medical Day was observed with a 25-lire stamp portraying Girolamo Fracastoro (1483-1553), physician, mathematician and philosopher. He was the personal physician to Pope Paul III.

Yugoslavia—Has released a nine-value series showing the medicinal plants and flowers of that country; printed in natural color.

Israel—Commemorated the 25th anniversary of Magen David Adom, the Israeli equivalent of the Red Cross, with the issuance of a 160-pruta stamp.

Finland—A series of three stamps with a surcharge for the benefit of the Red Cross.

‹ ›

Doctor-hospital relationships

To acquaint doctors with the official A.M.A. policy on the relationship of physicians and hospitals, a pamphlet has just been issued by the A.M.A.'s Council on Medical Service. This is something which should be read by all physicians who have hospital connections.

The pamphlet of 16 pages is made up of two reports adopted by the A.M.A. House of Delegates. One is "Guides for Conduct of Physicians in Relationship With Institutions," adopted in December 1951. The other, a supplement, is "Report of the Joint Committee on Hospital-Physician Relationships of the Board of Trustees of the American Medical Association and the American Hospital Association," adopted in June 1953.

Copies may be secured from the council.

‹‹‹ ›››

MEDICAL ECONOMICS

John R. Wolff, Chairman, Walter C. Bornemeier, Edward W. Cannady, Roland R. Cross, Jr., E. F. Dietrich, W. W. Fullerton, Edwin F. Hirsch, Frederic T. Jung, W. R. Malony, Caesar Portes, William Requarth, Frederick W. Slobe.

Some Economic Aspects of Health Resorts

FREDERIC T. JUNG, M.D., CHICAGO

IT has been difficult to define the relations of health resorts to the practice of medicine in the United States. In theory it ought to be possible for a physician to recognize the cases in which sojourn at a health resort would help the patient; it ought to be easy for the family physician to establish satisfactory relationships with physicians who are in charge at health resorts and to resume the care of the patient after he has returned home.

In practice, however, an initial difficulty has been to discover any scientific sense in the literature that has been written in praise of mineral waters. One writer lauds his water as being "rich in sodium chloride," as if table salt were a rare substance. Another writer tells unctuously of the radon content of his water and remarks how fast radon is exhaled again after inhalation treatments or after drinking radon-containing water; he is obviously ignorant of the fact that a given radon atom has no effect unless and until it discharges its alpha particle and so becomes an atom of the vicious substance polonium 218 (formerly called radium A). A third, in the year 1955, still sees curious virtues in the mud-bath, an expensive and inconvenient ritual that probably has nothing but psychological advantages over other forms of heat hydrotherapy.

The overwhelming mass of this literature has been a recounting of superstitions ascribed to the Aztecs, the ancient Romans, the American Indians, and other sources, with a meticulous reprinting of inconsequential chemical analyses and a cheerful by-passing of much recent information from the fields of pharmacology and bioclimatics. While the balneologist tries to make up his mind whether his mineral water is best for ailments of the kidneys, or of the liver, or of the spleen, the critical reader wearies of searching for anything conclusive in this haystack of words. At the same time the vendor of the mineral water may be preparing it for the market by distilling and carbonating it! This takes a load off the minds of potential buyers, who may have been confused by thoughts about the dangers of radium, the troublesome features of hydrogen sulfide, and the unfortunate effects of sodium chloride in cardiac edema. But it distresses those balneologists and hydrotherapists who are trying earnestly to shake themselves free of their heritage of confused thinking. Their work is important and often effective, but its rational basis needs to be made more secure by further critical investigations, especially by physiologists and psychologists.

A second difficulty has been that of assuring adequate medical direction at health resorts. A survey in 1938 revealed that only 10 such institutions in the United States had adequate medical direction. Efforts to improve this situation

have been made, but their effectiveness has been doubted. A hopeful sign has been the rapidly developing interest in rehabilitation programs. The immense potential usefulness of health resorts in rehabilitation was sketched by Krusen[1] in 1944. Since rehabilitation of the sick and injured is the aim of every physician no matter what his specialty, these possibilities should excite widespread interest. The integration of an existing health resort into a rehabilitation plan would create a much more favorable atmosphere for medical supervision and would help to discourage cultism and quackery. It is logical to hope that these possibilities will be thoroughly explored.

A third difficulty affects the health resorts of other countries in varying degrees, but is especially perceptible in the United States. Whether or not the need for uninhibited physical activity is innate in Americans, and whether or not the unwillingness to be fenced in is a national characteristic, the fact is that two or more weeks of passivity in a health resort, with improvement slow and expenses high, is unsuited to their temperament. A German exchange student who recently crossed the Atlantic on a liner boasting a Finnish sauna remarked about some American students, "They exercise even in the steam room!" Partly as a result of this restlessness, the use of American health resorts has been notably sensitive to seasonal and economic[2] swings. This has been aggravated in recent years by the fact that vitamins, hormones, sulfas, and antibiotics, especially when injected, sometimes give much quicker results.

In view of these facts, extraordinary interest attached to an article "La crise du thermalisme francais" that appeared in the monthly "Ecrits de Paris" in May 1954 and was discussed at length in the German monthly "Heilbad und Kurort" in February 1955. In the original article, Sarraz-Bournet sketches the history of French balneology since Gallo-Roman times and then gives statistics regarding the present status of French health resorts.

He states that France at the time of writing was using about 1,200 different natural "healing" springs, which supplied the therapeutic needs of 120 institutions in 75 recognized places. The statistics show that in 1951 these facilities were used by 290,000 people (including 51,000 foreigners). In 1953 they were used by only 251,000 people (including only 31,000 foreigners). Other figures likewise indicated that patronage by foreign guests for varied reasons was falling off badly. The following is translated from the German summary of Sarraz-Bournet's article:

"The French social insurance arrangements allow or 80 per cent of the charges for treatment and of physicians' fees; they also pay part of the expenses for travel and lodging. In spite of the advantages so granted, a large number of people with this form of social insurance had to get along without their course of bath-treatments because they did not have the additional money needed to finance their stay at the health resort. Of the potential guests who are cared for by social security arrangements, many go to baths in Germany and Italy. In Baden-Baden alone, in 1953, according to Sarraz-Bournet, 6,200 French patients took the treatment. Even if one allows for the fact that this number must have included men from the French army of occupation, it must be considered astonishing. The explanation is assumed to lie in the better organization of the health resorts, the new technical installations, the food at the hotels, and the low prices charged for lodging.

"Sarraz-Bournet comes to the conclusion that apparently the French system of health resorts is in a state of crisis. It is his opinion that the French baths have not met the requirements for improving their services. (He says that) of the funds from the Marshall Plan, 500 million have been made available to the health resorts, but as a loan that was to be repaid. But what is needed unconditionally (he said) is subsidies. Since official arrangements for bank loans toward necessary construction have been lacking, the system has felt for a long time the need of loan funds earmarked for baths similar to those that have been granted, for instance, to owners of hotels. The hope for such loans to baths, however, could not be fulfilled because of objections from the Ministry of Finance."

Among the things that invite thought in this passage is the evidence that for some individuals any given amount of money from social security

1. Krusen, Frank: The Place of Health Resorts in Rehabilitation Following Injuries, J.A.M.A. **125**:905-911 (July 29.) 1944.
2. Simons, A.M.: Economic Aspects of Health Resort Therapy, J.A.M.A. **124**:33-35 (Jan. 1) 1944.

sources is not quite enough. It also illustrates the immense difficulty of administering loan funds and of placing credits from such enterprises as the Marshall Plan where they will do more good than harm. But especially it indicates the importance that is attached in Europe to something that is still imperfectly worked out in the United States, namely the proper use of health resorts.

The detrimental physical effects of excessive bed rest have been much studied in recent years; they were brought out especially in a series of articles by Harrison, Eastman, Powers, Dock, and Ghormley.[3] But the confused thinking that sometimes underlies the so-called "trip treatment", the fact that enforced idleness is sometimes exactly the wrong thing for the psychiatric patient, and the detrimental psychological effects of excessive or uncalled-for mental rest was brought out by Menninger[4] in the concluding article of the series.

Perhaps American health resorts should develop in the direction so clearly manifested in American summer camps. Thought of by many uninformed people as places for idleness, the best summer camps are really extremely busy places. The successful director aided by an industrious staff is not only able to keep the campers constructively occupied from sunup to nightfall, but also knows how to weave them into responsibilities that bring important social and occupational experience. The beneficial effects on some personalities are strikingly beneficial. The camp becomes an integrated, balanced community instead of something one-sided and parasitic. At the same time it becomes less expensive.

The idea of summer camps for older people is now being developed, and the next logical step would be year-round communities, nearly self-supporting, where people could gain the benefits of a change of social and geographic environment without forfeiting the benefits of interesting, productive work.

When locations can be found where nature supplies preheated water for washing, swimming, and hydrotherapy, so much the better. The saving is obvious, so that finespun arguments about such things as aperients, peloids, and trace elements are gratuitous. The United States has attractive regions answering that description. The late Dr. Richard Kovacs used to exhibit a magnificent collection of colored transparencies in proof of this. The problem of making economical use of these natural resources deserves continued attention.

3. J.A.M.A. 125:1075-1087 (Aug. 19) 1944.
4. Menninger, Karl: The Abuse of Rest in Psychiatry. J.A.M.A. 125:1087-1090 (Aug. 19) 1944.

« « « » » »

Acute cholecystitis

Acute cholecystitis usually results from obstruction of the cystic duct by calculi. Unless surgical treatment is carried out early, the condition may progress rapidly to the point of complications such as gangrene, perforation, abscess formation, hydrops, or dense adhesions, rendering proper surgical therapy difficult. A series of 50 cases of acute cholecystitis (diagnosed pathologically) is reviewed, with reference to the clinical findings, the diagnosis and the preoperative and operative management. In all cases, operation was performed as soon as the diagnosis was established and the patient properly prepared for surgery. The mortality rate of the series was zero and no postoperative complications could be directly attributed to the surgical procedure. *Meredith J. Evans, M.D. Management of Acute Cholecystitis. West Virginia M. J. August 1955.*

THE P. R. PAGE



1956 a momentous PR year

Nineteen Fifty Six will be a momentus year in medical public relations.

The outlook is beclouded. Dangerous legislative proposals are on the federal agenda. Only hard work on the part of doctors will prevent the taking of another — and big — step toward the socialization of medicine.

There is a complacency about the whole thing which is disturbing. Many physicians are aware of the dangers, and have been trying to arouse their colleagues. Unfortunately, too many are content to sit on the sidelines and watch others carry the ball. Never has there been more need for concerted teamwork than right now.

When Congress resumes its deliberations in January, it will have before it many matters pertaining to medical practice. Perhaps the most important will be H. R. 7225. That measure had easy sailing in the House of Representatives before adjournment last June. It will have easy sailing in the Senate unless something is done to block it.

H. R. 7225 provides for numerous changes in the Social Security Act. The greatest threat to medicine is that section which would make permanently and totally disabled persons 50 years or older eligible to receive cash benefits now restricted to those 65 years or over.

On first thought, this would seem to be a desirable way of taking care of the disabled — and the public is being "sold" on that basis. Actually, this paves the way for putting the federal government into medical practice because it would require machinery to determine disability.

The ethical physician would be honest in this determination. However, the unethical doctor — and there are some, over whom medical societies have no control — would not hesitate to declare a patient disabled, especially if he were under political pressure to do so.

Aside from the inherent dangers of the present proposal, its adoption would merely be a step toward further broadening of the Social Security benefits base. Eventually, cash benefits and medical care could be provided for any one disabled, permanently or temporarily. Where there would be a halt, nobody knows.

There are many more bad features of H. R. 7225. Consequently, it is to be hoped that the measure not only will be given a thorough hearing before the Senate finance committee but that an exhaustive study of its potentialities will be made *before* it becomes law.

The medical profession has two courses open to it to prevent the passage of a measure which is a definite threat to the health and welfare of this nation.

One is for doctors to assume their individual responsibilities and to impress their Senators with the dangers which exist. This is a duty incumbent upon every loyal citizen who has consideration for the stability of his country.

Next, is informing the public of these dangers so that there will be enough demands upon members of the Senate that they will have to give

the resolution careful thought and not be stampeded into approval such as occurred in the House of Representatives.

This is a public relations job which lies just ahead. The medical profession cannot afford to fall down. There is too much at stake.

‹ ›

U. S. health spending

Federal spending for health and welfare shows which way the wind is blowing. And the wind is taking on hurricane proportions.

In the 1956 fiscal year, the total health budget, according to a compilation made by the Washington office of the AMA, is approximately $2,269 millions, an increase of $137 millions over this year. However, a decrease of $36 millions in the health spending of the Department of Defense serves to minimize the danger partially.

Two agencies — Veterans Administration and Department of Health, Education and Welfare — will be spending $1,317 millions, an increase of $163 millions. It is in those agencies that one finds the greatest trend toward socialized medicine. The VA's health budget is being upped 5 per cent; HEW's, 7 per cent.

Both agencies are carrying their propaganda to the public through large publicity departments financed by taxes. The only way the medical profession can prevent being wrecked by the oncoming storm is to build a strong defensive wall in the form of public opinion.

That is another PR job ahead for 1956.

‹ ›

New television aids

To aid in the PR programs of medical societies, the AMA Bureau of Health Education and the National Society for the Prevention of Blindness have prepared two new television "scripts-with-film" presentations dealing with the eye. These shows are designed so that a local physician can narrate while the film is thrown on the television screen.

One, "A Clear Picture," deals with the eye and its functions. It includes an animated sequence using a fresh orange, a glass lens, and a piece of lipstick to show the structure of the eye. "Wonderful Spectacle" describes the functions of glasses and lenses. Dr. Brittain F. Payne, New York ophthalmologist, is the film demonstrator.

Each program is 15 minutes in length, but it may be combined into a 30-minute presentation. The films and scripts may be had through the AMA TV film library. There is no cost to medical societies.

‹ ›

A PR gesture

Wally Carlson, Chicago Tribune Syndicate artist, in one of his "Mostly Marlarky" cartoons recently, showed the wife with a letter in her hand and saying to her husband: "Isn't that thoughtful. Dr. Mart put a get-well card in with his bill." Here is a PR gesture worth considering in selected cases.

‹‹‹ ›››

Influences at work

At the present time, powerful forces are at work that may affect the environment of medicine for good or evil. These are, to a large extent, the result of the industrial age in which we live. The drive in the direction of socialization of medicine, the rapid expansion of federal medicine, the emphasis on group and co-operative medicine, on comprehensive care under industrial and labor aegis are with us. I mention these not to condemn or defend them at this time, but merely to point out that these influences are at work and we must strive to understand them and consider their effect, not only on the quantity but on the quality of medicine that may in the future be available to our people. *Walter B. Martin, M.D. Medicine in an Industrial Civilization. Texas J. Med. July 1955.*

CORRESPONDENCE

Clinics for Crippled Children Listed for January

Twenty-five clinics for Illinois' physically handicapped children have been scheduled for January by the University of Illinois Division of Services for Crippled Children. The Division will count 20 general clinics providing diagnostic orthopedic, pediatric, speech, and hearing examination along with medical social and nursing service. There will be three special clinics for children with cardiac conditions, one for children with rheumatic fever and one for cerebral palsied children.

Clinics are held by the Division in cooperation with local medical and health organizations, both public and private. Clinicians are selected among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

The January clinics are:

January 4 - Hinsdale, Hinsdale Sanitarium
January 5 - Sterling, Field House
January 5 - Clinton, Christian Church
January 10 - Peoria, Children's Hospital
January 10 - E. St. Louis, St. Mary's Hospital
January 10 - Quincy, St. Mary's Hospital
January 11 - Joliet, Will County T. B. Sanitarium
January 12 - Elmhurst Cardiac, Memorial Hospital of Dupage County
January 12 - Litchfield, Madison Park School
January 12 - Mt. Vernon, Masonic Temple
January 12 - Springfield, St. John's Hospital
January 13 - Chicago Heights Cardiac, St. James Hospital
January 17 - Alton, Alton Memorial Hospital
January 17 - Danville, Lake View Hospital
January 17 - Effingham (Rheumatic Fever), St. Anthony's Hospital
January 18 - Aurora, Copley Memorial Hospital
January 18 - Evergreen Park, Little Company of Mary Hospital
January 18 - Springfield (Cerebral Palsy), Memorial Hospital
January 19 - Bloomington, St. Joseph's Hospital
January 19 - Cairo, Public Health Building
January 19 - Rockford, St. Anthony's Hospital
January 20 - Evanston, St. Francis Hospital
January 24 - Peoria, Children's Hospital
January 25 - Salem, Masonic Temple
January 27 - Chicago Heights Cardiac, St. James Hospital

‹ ›

Midwinter Seminar in Ophthalmology and Otolaryngology

The 10th Annual University of Florida Midwinter Seminar in Ophthalmology and Otolaryngology will be held at the Sans Souci Hotel in Miami Beach the week of January 16th., 1956. The lectures on Ophthalmology will be presented January 16, 17, and 18 and those on Otolaryngology on January 19, 20, and 21. A midweek feature will be the Midwinter Convention of the Florida Society of Ophthalmology and Otolaryngology on Wednesday afternoon, January 18, to which all regis-

trants are invited. The registrants and their wives also may attend the informal banquet at 8 p.m. on Wednesday. The schedule has been changed to provide a maximum time for recreation each afternoon.

The Seminar lecturers on Ophthalmology this year are: Dr. Francis H. Adler, Philadelphia; Dr. A. Gerard DeVoe, New York; Dr. Michael J. Hogan, San Francisco; Dr. C. Wilbur Rucker, Rochester, Minnesota; and Dr. A. D. Ruedmann, Detroit, Michigan. Those lecturing on Otolaryngology are: Dr. Frederick A. Figi, Rochester, Minnesota; Dr. Lewis F. Morrison, San Francisco; Dr. Charles E. Kinney, Cleveland; Dr. John R. Lindsay, Chicago; and Dr. Bernard J. McMahon, St. Louis.

‹ ›

American Board of Obstetrics and Gynecology

The next scheduled examination (Part I), written examination and review of case histories, for all candidates will be held in various cities of the United States, Canada, and military centers outside the continental United States, on Friday, February 3, 1956.

Case abstracts numbering 20 are to be sent by the candidates to the Secretary as soon as possible after receiving notification of eligibility to the Part I written examination.

Office of the Secretary—Robert L. Faulkner, M.D.
2105 Adelbert Road
Cleveland 6, Ohio

‹ ›

American Academy for Cerebral Palsy Officers

At the meeting of the American Academy for Cerebral Palsy, Memphis, Tennessee, October 10, 11, and 12, the following officers were elected for the forthcoming year:

Dr. Margaret Jones, President
University of California Medical Center
Los Angeles, California

Dr. Nicholson J. Eastman, President-Elect
Johns Hopkins Hospital
Baltimore, Maryland

Dr. Robert A. Knight, Secretary-Treasurer
869 Madison Avenue
Memphis 3, Tennessee

The 1956 meeting will be held in Chicago; the 1957 meeting will be held in New Orleans.

Notice of V Congress of Pan American Medical Women's Alliance

The *V* Congress of the Pan-American Medical Women's Alliance will be held in Santiago and *Vina del Mar,* Chili, March 6 to 13th, 1956. A pre- and post-congress trip is planned to include visits to hospitals and medical clinics in Mexico, San Salvador, Panama, and Peru.

A week's precongress trip is planned in the lake region of southern Chile under the guidance of some of the Chilean women doctors. Following the Congress a week will be spent in La Paz, Bolivia, visiting their medical projects among the Incas. En route to Lima there will be a day trip across Lake Titacaca and ample opportunity to explore the archeological treasures of Cuzco and Macchu Picchu. Arrangements may be made to shorten or lengthen the planned itinerary. Papers will be read on:

Medical Problems of Women in Medicine, Infertility, Family Security, Cancer, Miscellaneous Subjects.

Information may be obtained from the Secretary, Dr. Eva F. Dodge, 2124 West 11 Street, Little Rock, Arkansas, or from the Program Chairman, Dr. Eva Cutright, Wooster, Ohio.

‹ ›

Northwestern University Medical School Course in Radiation Physics

The annual course in Radiation Physics for residents in radiology at the hospitals associated with Northwestern University Medical School will again be open to all interested physicians.

It will be given on Monday and Thursday evenings 7:00 to 9:00 p.m. in the third floor conference room at St. Luke's Hospital.

Tuition fees: Residents: $10.00; practicing and other physicians: $25:00. To make application write to: Director Graduate Division Northwestern University Medical School, 303 E. Chicago Avenue, Chicago, Illinois.

‹ ›

Intestinal Research Institute

The Intestinal Research Institute has been incorporated in New York State as a nonprofit educational, research foundation for the study of intestinal diseases. The incorporators are Dr. Earl J. Halligan, International Secretary General of the International Academy of Proctology and Director of Surgery, Jersey City Medical Center; Dr. Alfred J. Cantor, Editor of

the American Journal of Proctology; Dr. Louis Wegryn, President of the International Academy of Proctology; and Dr. Paul Lahvis, Chairman of Foreign Chapters Committee of the Academy.

An initial project on the possible virus etiology of ulcerative colitis is planned. Eminent virologists in the United States have been contacted, and a grant for this study will be established.

A research laboratory to study the etiology and pathogenesis of ulcerative colitis has also been established at 147-41 Sanford Avenue, Flushing, New York, headquarters of the International Academy of Proctology.

Intestinal Research Institute funds will come primarily from contributions and grants. An initial grant of $3,000.00 has been provided by the International Academy of Proctology. All physicians are offering an opportunity to affiliate with the Intestinal Research Institute as Contributing Founders.

For full details write to the Intestinal Research Institute, Office of the Director, 147-41 Sanford Avenue, Flushing, New York.

‹ ›

Officers of Chicago Council of Child Psychiatry

At the fall meeting of the Chicago Council of Child Psychiatry the following assumed their elective offices

President — Irene Josselyn M. D.
President Elect — Adrian Vander Veer M. D.
Secretary-Treasurer — H. M. Segenreich M. D.
Executive Councillors — Anne Benjamin M. D.
Elsie Haug M. D.
George Perkins M. D.
Program Chairman — Harold Balikov M. D.

‹ ›

Central Society of Nuclear Medicine

The Central Society of Nuclear Medicine was recently organized as a regional society to encourage and promote interest, work and investigation in the field of nuclear medicine.

The Society is open to physicians and other professional workers in the field.

It is planned to have three meetings per year.

The following officers were elected at the first meeting:

Irvin F. Hummon, M.D.	President
Donalee Tabern, Ph.D.	Vice President
Ervin Kaplan, M.D.	Treasurer
Robert S. Landauer, Ph.D.	Secretary

All those interested are invited to contact the secretary:

Robert S. Landauer, Ph.D.
Radiation Center Building
1903 W. Harrison Street
Chicago 12, Illinois

‹‹‹ ›››

The price of success

Sometimes a man, by hard work and ability, gets to the top and is looked upon by the world as a great success, but occasionally this success has been bought at too high a price—en route he has lost his family. The situation is particularly difficult if boys are involved. Like as not, the father has had little time for them; perhaps because they do not possess his drive he has written them off—this is tragic. Boys need a father or a father surrogate in order to develop masculine identification, and I have seen more successful executives than I care to recount who had to take this problem into account too late to do anything about it. Obviously, success is not worth this loss—it turns bitter in one's mouth. It is a potent source of pressure upon the busy executive to have lost his family while he fought his way up. *Francis J. Braceland, M.D. Emotional Problems among Executives. Med. Ann. District of Columbia, May 1955.*

NEWS of the STATE



ADAMS

Pilot Heart Study of Children.—The Heart Committee of the Adams County Medical Society, in co-operation with the Adams County Chapter of the Illinois Heart Association, was to have launched a pilot study of all school children in several grades in one of Quincy's public schools in November. The purpose is to detect early, acute rheumatic fever, one of the principal causes of crippling heart disease in children. It has already been shown elsewhere that this frequent cause of heart disease can be virtually wiped out by such studies, when combined with proper treatment. Full details of this important study in Quincy of the main cause of heart disease in school children will be announced shortly.

Society Activities.—Mr. Paul R. Weaver, Charter Life Underwriter of Monmouth, addressed the Adams County Medical Society at the Lincoln-Douglas Hotel, Quincy, October 11, on "Estate Planning", emphasizing the various taxation phases of the problem.

Personal.—Newly elected members of the Adams County Medical Society are Drs. William U. McReynolds and Donald M. Wright, both of Quincy.

COOK

Pediatric Meeting.—A joint meeting of the Chicago Pediatric Society and the Chicago Laryngological and Otological Society was held, November 4, at the Furniture Club of America. The speakers were Doctors Philip Rosenblum and John R. Lindsay on "The Present Status of Otitis Media." Drs. Thomas C. Galloway and Erich Uhlmann spoke on "The Tonsil Problem: Surgery or Irradiation?" and a group from the Michael Reese Hospital, including Robert Henner, F. J. Pollock, P. A. Campanelli, M.A., M. W. Judiesch, M.A., and Doris P. Wheeler, presented "The Team Approach to Speech and Hearing Disorders." Discussions were led by Doctors Francis L. Lederer, George Livingston, and Helmer Myklebust, Ph.D.

Belfield Lecture.—Dr. Russell D. Herrold presented the Twenty-seventh Annual William T. Belfield Memorial Lecture of the Chicago Urological Society, October 27. His subject was "The Story of Antimicrobial Agents for Urinary Infections and Some New Concepts." This year the wives of the members were invited for cocktails and dinner, an innovation for the Belfield meeting. During the lecture the wives were entertained with a talk on "Present Trends in Interior Decorating" by Mr. Robert Pemberton, director of Interior Design, Chicago Academy of Fine Arts.

Monetary Gift Honors William Danforth.—Evanston Hospital has received a gift of $100,000 from Mr. and Mrs. John J. Louis, Sr., Evanston, in honor of the memory of Dr. William Danforth who died in 1949. In making the gift available, the donors said that it was because of their admiration of the late Dr. Danforth who delivered their sons John Jr., Michael, and Herbert. The last named, also a physician, is now serving a residency at Hines Hospital. Dr. Danforth had been professor emeritus of gynecology and obstetrics at Northwestern University Medical School. He bequeathed the hospital $50,000. The funds will be used to help pay for a new building and expansion costs at the hospital as well as a new obstetrical department.

Faculty Changes.—Recent appointments to the faculty of the Chicago Medical School include the following: in the department of medicine, Dr. Lee H. Schlesinger, clinical associate professor; Dr. James B. Aerardi, clinical instructor; Dr. Edwin Feldman and Dr. Jerome J. Podgers, clinical assistants; and Dr. Arnaldo Libretti, research fellow in allergy. In the department of pathology: Dr. Paul B. Szanto, associate professor, and Dr. Johnathan B. Horrell, clinical instructor; in the department of psychiatry: Dr. Joseph W. Friedlander, associate professor; and in the department of surgery. Dr. Harry H. Le Veen, associate professor; Dr. Bertram Levin, clinical associate



Presidents of national, state and county auxiliaries attending the Fall Conference of the Woman's Auxiliary to the Illinois State Medical Society, October 6, 1955, at the Sheraton-Blackstone Hotel, Chicago. (1) Mrs. Albert J. Nehf, Kankakee County; (2) Mrs. Mason G. Lawson, Woman's Auxiliary to the American Medical Association; (3) Mrs. Warren W. Young, Woman's Auxiliary to the Illinois State Medical Society; (4) Mrs. J. C. Garland, Kane County; (5) Mrs. John T. France, McLean County; (6) Mrs. Wylie H. Mullen, Will-Grundy County; (7) Mrs. W. W. Davidson, President-Elect Marion-Clinton County; (8) Mrs. Leonard J. Houda, Cook County; (9) Mrs. Gilbert H. Edwards, Perry County; (10) Mrs. Armand J. Mauzey, DuPage County; (11) Mrs. Harry A. Mittleman, Madison County; (12) Mrs. Robert Borrowman, DeKalb County; (13) Mrs. Robert Hart, Peoria County; (14) Mrs. B. Smith Hopkins, Jr., Champaign County; (15) Mrs. Richard E. Icenogle, Warren County; (16) Mrs. J. R. Burnett, Effingham County.

professor of radiology; Dr. Helen L. Button, clinical instructor; and Dr. Paul R. Rosenbluth, clinical instructor in neurosurgery.

Promotions at the school included: Dr. David Presman, clinical associate professor of urology; Dr. Samuel R. Rubert, clinical assistant professor of orthopedic surgery; Dr. Howard H. Bass, clinical associate in urology; Dr. Robert D. Crane, clinical associate in surgery; Dr. Louis Richmond, associate in medicine; and Dr. Lester Wishingrad, instructor in pediatrics.

Illinois Physicians Made Fellows in Gastroenterology.—Ten Chicago physicians were inducted as fellows in the American College of Gastroenterology at the annual convocation in the Shoreland Hotel, Chicago, October 23. They are:

Drs. Arkell M. Vaughn, past president of the Illinois State Medical Society; Walter C. Bornemeier, past president of the Chicago Medical Society; Arthur J. Atkinson, Herman F. DeFeo, Vincent J. Galante, William B. Knapp, Mitchell A. Spellberg, Harry A. Oberhelman, George J. Rukstinat, and John P. Waitkus.

Inducted as associate fellows were: Drs. Jerome Forman, Samuel L. Governale, Benjamin F. Gordon, and Leonard F. Kowalski. Dr. John B. Karr was made a member. All are from Chicago.

Dr. Burt J. Canfield of Rockford was made an associate fellow.

At the annual meeting, Dr. Edward J. Krol, Chicago, was elected a trustee.

Wilder Penfield Gives Fraternity Lectures.—Dr. Wilder Penfield, Director of the Montreal Neurological Institute, gave the Phi Epsilon Fraternity Lectures recently. The first, on "Permanent Record of the Stream of Consciousness," was given at Mount Sinai Hospital, October 31, in honor of Dr. Harry C. Rolnick. The second, on "Voluntary Movement—Some Observations on the Role of Centrencephalic Control", was presented in Thorne Hall, Northwestern University, November 1, in honor of Dr. Carl A. Dragstedt. The third lecture, on "Results of Treatment of Focal Epilepsy by Cortical Excision", was given at the University of Illinois College of Medicine, November 2, in honor of Dr. Francis E. Senear.

The Artery Bank.—On October 11 a Central Artery Bank was opened, in the Hektoen Institute for Medical Research; it is supported by the Chicago Heart Association. Procurement of suitable arterial segments is based on the large postmortem material of the Cook County Hospital. Sterilization, lyophilization, and storage of blood vessels are accomplished at the bank. Segments can be obtained

by those whose training in vascular surgery is known or for whose ability the surgical staff at the requesting hospital can vouch. Surgeons interested in obtaining such segments may obtain further information by calling Miss Naomi McElwain at MOnroe 6-0787.

Physician Honored.—A testimonial dinner was held in honor of Dr. James Toman, a member of the staff of Chicago Medical School for his services to the community. The dinner was sponsored by the North Kenwood-Oakland Community Conference in the community center recently.

Harry Dale Retires.—On October 28 the retirement of Dr. Harry Dale was announced, bringing to a close fifty-three years of service as a physician and thirty-six years of practice of medicine in Chicago Heights. As a token of goodwill towards St. James Hospital, with which he has been associated since May 1919, Dr. Dale presented to it his valuable collection of medical and surgical instruments. The equipment includes delicate eye surgery apparatus as well as tonsil, mastoid, and nose and throat materials. Dr. Dale has held every medical staff position at St. James, including the presidency of the staff in 1940. Quoting Dr. Dale from an interview, the Chicago Heights Star reported him to say that "Medicine has come a long way in over a half a century. When I began practice with my father in McLeansboro down in Southern Illinois, it was a true horse and buggy profession. I can remember driving miles in my buggy over many roads to deliver babies, or do some kitchen table surgery because the nearest hospital was 60 miles away. Times have sure changed." In the future Dr. Dale and his wife will winter in Florida, returning to Chicago Heights in the summer.

Hospital Observes Fiftieth Anniversary.—Columbus Memorial Hospital observed its fiftieth anniversary, October 12, at a dinner in the Conrad Hilton hotel attended by more than 600 persons. Cardinal Stritch paid tribute to the hospital's founder, Mother Cabrini, later beatified as St. Frances Xavier Cabrini, who established the Missionary Sisters of the Sacred Heart, operators of the hospital.

Pietro Guadagnini, Italian consul general in Chicago, presented the Gold Star of Solidarity to three staff physicians: Dr. Karl Meyer, chief surgeon; Dr. August F. Daro, head of the women's department, and Dr. Peter Rosi.

Dr. Edward Foley, head of the hospital's department of medicine, asserted that a hospital requires a spirit of humility to function properly. A good hospital, he said, should be a place where a patient goes in dignity to be ill, rather than to become a statistic in a research problem.

Mayor Daley expressed gratitude to the Missionary Sisters of the Sacred Heart for their fifty years of service to the city. Dr. Meyer presented gold keys for twenty-five years' service to 11 physicians on the staff.

Personal.—Dr. Jules H. Wasserman, professor of neurology and psychiatry, and Richard A. Waterman, associate professor of anthropology, both of Northwestern University faculty, attended the sixth annual conference of the National Music Therapy Association in Detroit, October 6-8. Dr. Wasserman, a first vice-president of the association, moderated a panel on the sociological and psychological implications of music therapy, while Mrs. Waterman spoke on "Form and Meaning of Australian Aboriginal Music."—Dr. Aaron Arkin has been named president of the Chicago Diabetic Association. He is professor of medicine at the University of Illinois College of Medicine, professor of medicine and a trustee of Cook County Graduate school, and a trustee of Hektoen institute as well as attending physician and chairman of the department of medicine at Weiss Memorial hospital.—Dr. Fay H. Squire, director of the department of radiology at Presbyterian Hospital, has been elected Treasurer of the American College of Radiology, succeeding Dr. Earl E. Barth, also of Chicago.

Retirement Problems of Industry.—On November 30, a conference was held on "Retirement Problems of Industry." The meeting, which is said to be the first of its kind ever held in Chicago, will be held under the joint auspices of the Chicago Association of Commerce and Industry and the Chicago Heart Association. The speakers were representatives of industry and medicine. Participating doctors of medicine will be Irving S. Wright, Morris Fishbein, and George V. LeRoy.

New Head of Anatomy at Illinois.—Dr. Samuel R. M. Reynolds has been appointed professor and head of the department of anatomy at the University of Illinois College of Medicine, effective January 1. The appointment fills the vacancy created when Dr. Arthur Kirschbaum resigned in 1954 to assume the anatomy department direction at Baylor University College of Medicine. Dr. Parke H. Simer has been serving as acting head of the department at Illinois. Dr. Reynolds received his A.B. and M.A. degrees from Swarthmore College, Swarthmore, Pa., and his Ph. D. from the University of Pennsylvania in 1931. Currently he is director of the department of embryology at the Carnegie Institute of Washington, where he has been serving since 1941.

Appointments at University of Chicago.—Dr. Ruth Rhines, a neuroanatomist specializing in the study of the development of the nervous system, has been appointed associate professor of anatomy at the University of Chicago School of Medicine. William K. Baker, geneticist, has been named to the faculty as associate professor of zoology.

DUPAGE

Personal.—John E. Milton, Evanston, was recently appointed administrator of the new Edward Hospital in Naperville.

ST. CLAIR

St. Clair Society News.—Dr. Grey Jones, As-

sistant Clinical Professor of Obstetrics and Gynecology, St. Louis University School of Medicine, addressed the St. Clair County Medical Society recently on "Retrodisplacement of the Uterus".

SANGAMON

Bulletin Receives Award.—The Bulletin of the Sangamon County Medical Society has received an Honor Award for Distinguished Service in Medical Journalism from the American Medical Writers' Association. The presentation was made at the Association's annual meeting in St. Louis, September 30. The Sangamon Bulletin award is in the category of publications of county and city medical societies whose membership is less than 500. No award has previously been given in this classification. A plaque symbolizing the award was received by the Bulletin editor, Jacob E. Reisch, M.D. at the Association's annual banquet.

The Honor Award comes to the Bulletin after 20 years of continuous publication. It was on October 3, 1935, that Doctor Schnepp proposed that the County Society establish a monthly publication. A committee of five consisting of Doctors Staben, then president of the Society, Schnepp, Graham, Herndon, and Henkel, was instructed to consider and effect the project. The first issue appeared in January, 1936. In March, 1936, by an amendment to the by-laws, the Bulletin became the official publication of the Sangamon County Medical Society. The amendment provided for an Editorial Board of five members to determine details and policies of advertising and editorial material. The original committee of organization was appointed as the Editorial Board with Doctor Schnepp to serve five years, Doctor Graham four years, Doctor Staben three years, Doctor Henkel two years, and Doctor Herndon one year.

Doctor Schnepp continued as editor until 1942, when his military service made a replacement necessary. Dr. Murray E. Rolens, author of the "Corn Crib," a feature of the bulletin, assumed editorship at this time and continued until 1946, when Doctor Schnepp returned. In 1948, editorship was assigned to Doctor Reisch, who still holds the position.

During the past several years the bulletin has grown from a 16 to a 48 page publication, with a state-wide circulation of almost 1,000. Numerous new departments have been included in its contents to add to its interest and value. Due credit and appreciation from the Sangamon County Medical Society must be expressed to the Bulletin's advertisers, local firms and national organizations, and to its publishers, Schnepp and Barnes, who have made its publication and success possible and who should share in this award.

Society News.—Dr. Lindon Seed, clinical associate professor of surgery, University of Illinois College of Medicine and Director of the Isotope Laboratory at Augustana Hospital, discussed "Newer Aspects in the Treatment of Thyroid Disease" before the Sangamon County Medical Society at a dinner meeting in the Elks Club, Springfield, November 3. Dr. George Milles, associate professor of pathology at Illinois and Pathologist at Augustana, spoke on "Pathologic Physiology of Thyroid Disease."

WARREN

Ernest Irons Gives Three Talks in Monmouth.—Ernest Irons, Past President of the American Medical Association, addressed the monthly forum of the Presbyterian Church in Monmouth, Sunday night, November 13. The title of his talk was "Professional Education for Citizenship." Dr. Irons also addressed a meeting of the faculty and student body of the Monmouth College in the morning and the dinner meeting held annually at which the Rotarians act as host to the Kiwanians.

WINNEBAGO

Television Series a Success.—"Your Baby and You," a television series being presented by the Winnebago County Medical Society, has been well received, according to the Bulletin of the Winnebago County Medical Society. The physicians who appeared in the early weeks of the series were Dr. E. T. Leonard, Jr., on immunizations; Dr. A. Currie Maimon, on "Growth and Development, From Infancy to Six Months," and Dr. J. Howard Laubscher, "Growth and Development; Six Months to One Year."

GENERAL

Chicago Born Scientist Wins Nobel Prize.—Vincent du Vigneaud, Ph.D., has won the 1955 Nobel prize in chemistry for his work in two hormones that help in childbirth and keep a check on vital organs, such as the kidneys, newspapers reported. The prize amounted to $36,720. Dr. du Vigneaud was born in Chicago. He received his bachelor of science degree in chemistry at the University of Illinois in 1923 and his master's degree in 1924. He returned to the Urbana faculty as assistant professor in the department of chemistry, serving from 1929 to 1932.

Institute on Premature Baby Care.—"Community Planning for Better Care of Premature Infants" was the theme of an institute, October 19, 26 and November 9. The first two sessions were held at the Little Company of Mary Hospital in Evergreen Park and the third session in the auditorium of the American Medical Association. The institute was designed for nurses in maternity departments of hospitals as well as the public health nurses who make home visits to premature babies following discharge from the hospital. The area covered Chicago and surrounding counties: Will, Kane, Lake, and DuPage. The institute was sponsored by the Illinois State Department of Public Health, local health departments and hospitals.

Among the subjects covered were: the physiology and care of premature babies; prevention and treatment of infant diarrhea, retrolental fibroplasia, and erythroblastosis fetalis; public health significance of

prematurity; and the physical facilities necessary for the care of premature infants.

Carl Moore Dies.—Carl R. Moore died October 16 in Billings Hospital, Chicago. Moore was an outstanding pioneer in the study of sex and the mechanism of its development, and the hormonal control of reproduction. He began his studies before sex hormones were isolated and contributed to their isolation. In medicine, his work on the effect of hormones aided in the development of treatment for prostate cancer in men and breast cancer in women. He had been a member of the faculty of the University of Chicago since 1914.

"Your Doctor Speaks" on FM Station WFJL.—The following physicians have recently appeared in transcribed broadcasts of **FM Station WFJL, Thursday evenings, at 7:45 p.m.** The series, entitled **"Your Doctor Speaks,"** is presented by the **Educational Committee** of the **Illinois State Medical Society:**

Donald I. Bell, instructor in medicine, Northwestern University Medical School, October 27, on Understanding Diabetes.

Melvin F. Blaurock, director of the Oak Park Neuropsychiatric Clinic, November 3, on What Is Our Future?

Richard A. Buckingham, assistant professor of otolaryngology, University of Illinois College of Medicine, November 10, on Preservation and Restoration of Your Child's Hearing.

Louis Malow, associate professor of surgery in the department of proctology, Chicago Medical School, November 17, on Painful Conditions of the Rectum.

Lectures Arranged Through the Educational Committee of the Illinois State Medical Society:

F. M. Nicholson, a member of the Committee on Nursing of the Illinois State Medical Society, Schurz Lee Tri Hi Y, November 15, on Nursing as a Career.

Morris Fishbein, professional lecturer at the University of Chicago School of Medicine, American Association of Blood Banks, November 20, on Medical Progress, 1955.

Joseph T. O'Neill, Chairman of the Council of the Illinois State Medical Society, Sheridan Elementary School P.T.A., November 21, on Child Psychology.

Winston H. Tucker, Commissioner of Health of Evanston, Women's Council of Max Strauss Center, November 22, on Evolution of Salk Vaccine.

Lectures Arranged Through the Scientific Service Committee of the Illinois State Medical Society:

Coye Mason, clinical assistant professor of pathology, University of Illinois College of Medicine, Ford County Medical Society at the Middlecoff Inn, Paxton, November 15, on Pathology of Common Diseases.

Aldo A. Luisada, associate professor of medicine, Chicago Medical School, LaSalle County Medical Society at the Kaskaskia Hotel, LaSalle, December 8, on Common Errors of Ascultation Revealed by Phonocardiography.

William H. Wehrmacher, instructor in medicine, Northwestern University Medical School, Whiteside-Lee County Medical Societies in Rock Falls, December 15, on Does That Pain in the Chest Mean Heart Disease?

John F. Hubbard, Mattoon, Wayne County Medical Society at the Fairfield Memorial Hospital, Fairfield, December 15, on Hysterectomy.

DEATHS

Frederick A. Berry*, Chicago, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1908, died October 11, aged 74.

Edgar O. Breakstone*, Chicago, who graduated at the Chicago Medical School in 1937, died November 3, aged 47.

Herman P. Davidson*, Chicago, who graduated at Johns Hopkins University School of Medicine in 1917, died October 9, aged 62. He was a member of the staffs of the Presbyterian and Chicago Memorial Hospitals.

Bourke Firfer*, Chicago, who graduated at the University of Illinois College of Medicine in 1938, died October 13, aged 42. He was vice president of the medical staff at the South Shore Hospital.

Thomas J. Foster, De Soto, who graduated at St. Louis University School of Medicine in 1903, died recently, aged 84. He had practiced medicine in Franklin, Williamson, Jackson, and Macon Counties before going to De Soto nine years ago.

Julius H. Hess*, Chicago, who graduated at Northwestern University Medical School in 1899, died November 2, aged 79, while on a vacation in Los Angeles. He was professor emeritus of pediatrics at the University of Illinois College of Medicine; senior attending physician and past staff chairman of Michael Reese Hospital, and past attending pediatrician and chairman of the Cook County Hospital pediatrics department.

Walter Louveria Hougland, Chicago, who graduated at St. Louis University School of Medicine in 1905, died September 13, aged 79.

Eugenia A. Klawans*, retired, Wilmette, who graduated at Reliance Medical College, Chicago, in 1910, died October 15, aged 69. She was known professionally as E. A. Miller.

James U. Long, Knoxville, who graduated at Missouri Medical College in 1888, died in Galesburg Cottage Hospital, August 15, aged 91, of lymphatic leukemia.

Frank J. Maha, retired, Dundee, who graduated at Bennett Medical College, Chicago, in 1900, died November 7, aged 81.

Ralph Rowland McCarthy, Downey, who graduated at the College of Physicians and Surgeons of

*Indicates member of the Illinois State Medical Society

Chicago, School of Medicine of the University of Illinois, in 1911, died June 9, aged 71, of pulmonary edema and emphysema.

John H. Opitz*, Chicago, who graduated at Loyola University School of Medicine in 1917, died October 16, aged 62.

Benjamin Perry, Chicago, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1905, died August 6, aged 78, of coronary occlusion.

William A. Rosenberg*, Chicago, who graduated at Loyola University School of Medicine in 1918, died November 3, aged 62. He was a member of the staff of Michael Reese Hospital.

Adolph J. Rosenblate*, Chicago, who graduated at Kiev Medical Institute, Kiev, Ukranian S.S.R., in 1928, died October 12, aged 62. He was director of the radiology department of Englewood Hospital.

Lloyd Albert Schipfer*, Chicago, who graduated at the State University of Iowa College of Medicine in 1907, died October 15, aged 71.

Louis Willard Shabat*, Chicago, who graduated at the University of Illinois College of Medicine in 1931, died October 21 of a heart attack shortly after addressing a noon meeting of the Chicago Bar Association. He was 48. He had gained national prominence as a medico-legal expert.

Louis Abbott Vertuno, Oak Park, who graduated at the Chicago College of Medicine and Surgery in 1911, died October 13, aged 72. He was a member of the staff of West Suburban Hospital.

J. C. Westervelt, Shelbyville, who graduated at Bennett Medical College, Chicago, in 1878, died October 30, aged 100. He was honored last year by the American Medical Association as the nation's oldest practicing physician.

*Indicates member of the Illinois State Medical Society.

‹‹‹ ›››

New York City in 1970

Many surveys have indicated that the suburbanite is in the middle income bracket, he is professionally or technically trained, and frequently has better than average education. Thus, the central cities are losing these people so necessary for a balanced community life. A recent report in the New York Times predicted that in 1970 New York City would consist of Puerto Rican and non-white populations to the extent of 28 per cent of the total population. This figure would represent large immigration. It would also represent important emigration—to the suburbs, in all probability. The ratio of old people to other groups is increased in central cities because of the outward movement of the younger groups. Conversely, suburbs have young groups with high percentages of children. The New York Times report also commented on this in predicting that by 1970 one in every eight in the city would be 65 years old or older. *Francis B. Elder. Effects of Suburbanization on Public Health in New Jersey. Public Health News, New Jersey Dept. of Health, June 1955.*

The cancer age

There is a positive correlation between cancer incidence and chronological age—the older the person, the greater the likelihood of cancer. Half of the people diagnosed with cancer were between 50 and 70 years of age. However, large variations exist between men and women relative to the parts of the body where cancer is found and the ages at which the disease manifests itself. Men appear more susceptible to cancer than women in the first two and the last two or three decades of the usual lifetime, whereas women have a higher rate during the childbearing years. In fact, at about age 35, approximately twice as many women as men are found to have a malignant tumor. After the childbearing period, however, the rate for males catches up with and exceeds the rate for females. *Harold F. Dom and Sidney J. Cutler. Cancer Morbidity in the U.S. Pub. Health Rep. July 1955.*

‹ ›

You can't see clearly if you insist on smoking up your glasses.

—*Amos Parrish*

REST COMES BEST to the relaxed patient.

Noludar relaxes the patient and usually induces sleep within one-half to one hour, lasting for 6 to 7 hours. Clinical studies in over 3,000 patients have confirmed the usefulness of Noludar in the relief of nervous insomnia and daytime tension. Noludar 'Roche' is not a barbiturate. Available in 50-mg and 200-mg tablets, and in liquid form, 50 mg per teaspoonful.

Noludar® -brand of methyprylon

Hoffmann - La Roche Inc

Nutley . N.J.



BOOK REVIEWS

KINESIOLOGY OF THE HUMAN BODY. Under Normal and Pathological Conditions. Arthur Steindler, M.D., Eng. F. A. C. S., F. I. C. S., (Hon.) F. R. C. S. Professor of Orthopedic Surgery Emeritus, State University of Iowa. Head of Orthopedic Department, Mercy Hospital, Iowa City, Iowa. $19.75. 691 pages. Charles C. Thomas, Springfield, Illinois.

This volume is divided into "parts;" each of the four parts is made up of so-called lectures. Part one deals with "General Kinetics" the physical properties of various tissues affected in motion. In this, attention if directed to the pages on cartilage will be well rewarded. To read this requires definite concentration. The very smallest items receive detailed description and logical deduction follows portraying the factual changes that result from motion changes. The reading flows easily, because of the author's style, but understanding the concept requires additional thought beyond the printed words. It makes one think. It might be said of this text, that its perusal will educate the reader in exactness of expression as well as in the actual facts of the subject itself.

What has been said of the work on cartilage is true of all subjects considered.

Part One deals also with The Mechanics of Joint and Muscle Action, Body Balance & Equilibrium, and the Measurement and Computation of Bodily Motion.

Part Two deals with Kinetics of the Trunk and in this also Respiration and Posture.

Part Three details the Mechanics of the Extremities and Joints and with the Pathomechanics of the Paralytic Joints. Also considered are sprains and fractures.

Part Four covers gait. And in addition to the Kinetics of normal gaits, pathological gaits including all varieties are evaluated. Even the prosthetic gaits are given well deserved space.

The jacket in which the book appears, among other statements says "it should be profitable reading not only for the educator", but particularly for the orthopedic surgeon and the physiatrist, whose efforts in rehabilitation stand and fall to the degree of serious interest and understanding *in the mechanics of normal and pathological locomotion.*

The index enables easy access to the subject desired; the printing is easily read, on paper "easy on the eye", and the arrangement of the text is admirable. There are illustrations, drawings, and photographs too numerous to calculate.

C. P. B.

‹ ›

COLLECTED PAPERS OF THE MAYO CLINIC AND THE MAYO FOUNDATION Edited by; Richard H. Hewitt, M.D., A. B. Nevling, M.D., John R. Miner, B.A.,Sc.D., James R. Eckman, A.B., M.A., Ph.D., M. Katherine Smith, B.A., Carl M. Gambill, M.D., Florence Schmidt, B.S.E., George G. Stilwell, M.D., 46th edition. $12.50 W. B. Saunders Company Philadelphia and London, 1955.

The material in this volume is composed of 629 papers, 62 appearing in full, 52 by abridgement, 20 by abstract and 495 by title only. The material was selected carefully with the interests of the general practitioner, the specialist and the diagnostician in mind. The field of medicine is well covered in this current volume, beginning with lesions of the alimentary tract, 127 pages being devoted to this subject.

A considerable amount of space is devoted to considerations of the blood and circulatory or-

(Continued on page 44)



Shorter R_x
to recovery
with fastest
tastiest
broad-spectrum
therapy

NEW palatability, **NEW** convenience, **NEW** versatility . . . the same unexcelled efficacy and toleration

TETRABON*

(unique fruit-flavor)

Brand of tetracycline

Supplied in 2 ounce bottles, containing 125 mg. tetracycline per 5 cc. teaspoonful.

TETRABON SF†

Brand of tetracycline hydrochloride with vitamins

(fruit-mint flavored)

Sugar free. Supplied in 2 ounce bottles, containing 125 mg. tetracycline per 5 cc. teaspoonful.

These new, remarkably palate-pleasing non-alcoholic homogenized mixtures of Pfizer-discovered tetracycline are now *standardized and ready-mixed* at Pfizer Laboratories for uniformity and reliability.

TETRABON SF supplies with each average daily dose of tetracycline the special vitamin formula recommended for the treatment of stress conditions, thus giving antibiotic therapy and metabolic support with a single prescription.

*Trademark
†Trademark for Pfizer-originated, vitamin-fortified antibiotics

NEW STANDARDS FOR TETRACYCLINE THERAPY IN NEW READY-MIXED LIQUID FORM

Pfizer PFIZER LABORATORIES, *Division, Chas. Pfizer & Co., Inc.*, Brooklyn 6, N. Y.

WE CORDIALLY INVITE YOUR INQUIRY for application for membership which affords protection against loss of income from accident and sickness (accidental death, too) as well as benefits for hospital expenses for you and all your dependents.



SINCE 1902

ALL PREMIUMS COME FROM PHYSICIANS SURGEONS DENTISTS

ALL BENEFITS GO TO

$4,500,000 ASSETS
$22,500,000 PAID FOR BENEFITS

PHYSICIANS CASUALTY AND HEALTH ASSOCIATIONS
OMAHA 2, NEBRASKA

gans. In this section the subject of anticoagulant therapy is given quite a little attention, and several papers deal with myocardial infarction, and with the newer types of surgery for the atrial septal defects. There are many interesting papers in this volume, as would be expected from those published in previous years.

The subject matter is well arranged and it is easy for the busy practitioner to find the subject of greatest interest at the moment.

‹ ›

BOOKS RECEIVED

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

Polio Pioneers — The Story of the Fight Against Polio. By Dorothy and Philip Sterling. With Photographs by Myron Ehrenberg and the National Foundation for Infantile Paralysis. Doubleday & Company, Inc. Garden City, New York. $2.75.

A Textbook of Clinical Pathology. Edited by Seward E. Miller, M.D., Medical Director, United States Public Health Service; Chief, Division of Special Health Services, Washington, D. C. Fifth edition. The Williams & Wilkins Company, Baltimore. $11.00.

Clinical Analgetics. By E. G. Gross, Ph.D., M.D., Professor and Head of Department of Pharmacology, State University of Iowa, College of Medicine, Iowa City, Iowa, and M. J. Schiffrin, Ph.D., Assistant Director of Clinical Research, Hoffmann-LaRoche, Inc., Nutley, New Jersey. Charles C. Thomas, Publisher, Springfield, Illinois. $3.00.

Classics of Biology. By August Pi Suner. Authorized English translation by Charles M. Stern. Philosophical Library, New York. $7.50.

Planning Florida's Health Leadership. Medical Education in the University. Edited by Louis J. Maloof. University of Florida Press, Gainesville, Florida. $1.50.

The Relief of Symptoms. By Walter Modell, M.D., F. A. C. P., Associate Professor of Clinical Pharmacology, Cornell University Medical College. 450 pages. W. B. Saunders Company, Philadelphia and London, $8.00.

Preventive Medicine in World War II. Medical Department, United States Army. Volume 11 — Environmental Hygiene. Editor in Chief, Colonel John Boyd Coates, Jr., MC, Editor for Preventive Medicine, Ebbe Curtis Hoff, Ph.D., M.D., Office of the Surgeon General, Department of the Army, Washington, D. C., 1955.

Corticotropin: Its Pharmacologic Effects in Man and Practical Therapeutic Utilization. By Gordon B. Myers, M.D., and William Q. Wolfson, M.D., Wayne University College of Medicine and Detroit Receiving Hospital, Wayne University Press, Detroit, 1955.





SPARES

INTESTINAL FLORA

This sensitivity test shows ERYTHROCIN and the same antibiotics against a typical intestinal strain of *E. coli*. Note that ERYTHROCIN and penicillin do not affect this gram-negative organism —although the other antibiotics show marked inhibitory action.

1. Eisenberg, et al., Antib. & Chemo., 3:1026-1028, Oct., 1953.

with little risk of serious side effects

Since ERYTHROCIN is inactive against gram-negative organisms, it is less likely to alter intestinal flora—with an accompanying low incidence of side effects. Also, your patients seldom get the allergic reactions sometimes seen with penicillin. Or loss of accessory vitamins during ERYTHROCIN therapy. *Filmtab* ERYTHROCIN Stearate (100 and 250 mg.) is supplied in bottles of 25 and 100 at pharmacies everywhere. Abbott

filmtab®

Erythrocin®

(Erythromycin Stearate, Abbott)

STEARATE

® Filmtab—Film coated tablets; patent applied for.



MARY POGUE SCHOOL, Inc.

Complete facilities for training retarded and epileptic children educationally and socially. Pupils per teacher strictly limited. Excellent educational, physical and occupational therapy programs.

Recreational facilities include riding, group games, selected movies under competent supervision.

Separate buildings for boys and girls under 24 hour supervision of skilled personnel.

Catalog on request

G. H. Marquardt, M.D. — *Medical Director*

Barclay J. MacGregor — *Registrar*

33 GENEVA ROAD, WHEATON, ILLINOIS

(near Chicago)

Accreditation troubles

The heights or depths of absurdity in the wild career of our bureaucracy gone to seed would seem to have been reached in the matter of compulsory attendance upon staff meetings at the Los Angeles County Hospital, where we have a membership in excess of 1,200 members of the Los Angeles County Medical Association, all freely giving their time to the indigent sick of the county. Under our masters' (The Joint Commission on Accreditation of Hospitals) decree, we must have at least four meetings a year with a 75 per cent staff attendance. This would require a hall large enough to accommodate 900 physicians. There is no such hall on the hospital grounds nor anywhere within a reasonable distance thereof. Consultation with the director of the Commission revealed him to be adamant in this requirement and to refuse utterly to give credit to physicians for attending the many section meetings held in the hospital every month. His only suggestion was a shrugging reference to the documentary essential for accreditation and the statement that staff attendance itself was only one of the long list of requirements; that failure in that particular instance would not necessarily bar a hospital from the coveted approval. While this ruling has been somewhat ameliorated after considerable pressure upon our masters, nonetheless it illustrates beautifully what happens when power is unduly and unwisely concentrated. *L. A. Alesen, M.D. Private Bureaucracy Gone to Seed. Bull. Acad. Med. Toledo and Lucas Counties. Nov.* 1955.

‹ ›

The incidence of persons now harboring tubercle bacilli varies greatly in different parts of the world. In nations with large populations where little effective tuberculosis control work has been done, so many children become infected that nearly all adults possess at least lesions of primary complexes containing tubercle bacilli. Among such people, a correspondingly high incidence of clinical tuberculosis is present. J. Arthur Myers, M.D., Journal-Lancet, April, 1955.

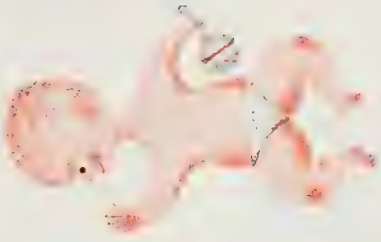
THE SPECIAL DISABILITY PLAN AVAILABLE TO MEMBERS OF THE ILLINOIS STATE MEDICAL SOCIETY Offers You — —

INDEMNITY FOR TOTAL LOSS OF TIME payable for up to
LIFETIME if due to an accident
7 YEARS if due to a sickness

HOSPITAL EXPENSE BENEFIT payable up to 90 days of confinement
ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

No reduction in benefits because of other similar insurance. Full benefits to age 70 at same cost.
(All benefits subject to provisions of the policies)

FOR ALL THE FACTS — — — WRITE OR TELEPHONE
PARKER, ALESHIRE & COMPANY
175 W. Jackson Boulevard
Chicago 4, Illinois **WAbash 2-1011**





Folic Acid ...and normal growth

When you prescribe a multivitamin product for an infant, a growing child, or a mother-to-be, make certain you choose one containing an adequate amount of Folic Acid. This B-complex vitamin is essential to the formation of all body cells, including red blood cells, and consequently, a vital factor in normal growth. Although essential to all, it assumes even greater importance during infancy and pregnancy.

So that you may conveniently prescribe a complete and adequate regimen for such cases, leading pharmaceutical manufacturers include Folic Acid in many of the vitamin preparations that they offer. This message is presented in their behalf.

Cyanamid Fine Chemicals

AMERICAN Cyanamid COMPANY

FINE CHEMICALS DIVISION

30 ROCKEFELLER PLAZA, NEW YORK 20, N. Y.

Another Lederle "First"!

MUMPS VACCINE

A practical immunizing antigen for prevention of mumps in children or adults where indicated.
Immunizes for about one year.
Packages: 2 cc. vial (1 immunization),
10 cc. vial (5 immunizations).

LEDERLE LABORATORIES DIVISION
AMERICAN Cyanamid COMPANY
PEARL RIVER, NEW YORK

Lederle

Foot-so-Port Shoe Construction and its Relation to Weight Distribution



- Insole extension and wedge at inner corner of heel where support is most needed.
- Special Supreme rubber heels are longer than most anatomic heels and maintain the appearance of normal shoes.
- The patented arch support construction is guaranteed not to break down.
- Innersoles are guaranteed not to crack, curl, or collapse. Insulated by a special layer of Texon which also cushions firmly and uniformly.
- Foot-so-Port lasts were designed and the shoe construction engineered with orthopedic advice.
- **NOW AVAILABLE! Men's conductive shoes. N.B.F.U. specifications. For surgeons and operating room personnel.**
- By a special process, using plastic positive casts of feet, we make more custom shoes for polio, club feet and all types of abnormal feet than any other manufacturer.

Write for details or contact your local **FOOT-SO-PORT** *Shoe Agency. Refer to your Classified Directory*

Foot-so-Port Shoe Company, Oconomowoc, Wis.

The Altered Prognosis in Diabetes Mellitus

Diabetes mellitus — the elevation of the sugar level of the blood and urine — is now believed to have one or more of these five causes:

1. Insulin deficiency
2. Liver deficiency
3. Pituitary gland deficiency
4. An insulin antagonist in the tissues
5. An abnormal substrate in the tissues that interferes with the normal chain or reactions involving insulin.

These possibilities are now under investigation, and the research may lead to a cure for diabetes.

Physicians' concepts of diabetes have changed considerably in recent years, particularly with the introduction of longer-acting insulins in 1938. Before insulin, the sole effort was to keep patients alive. At best, juvenile patients died in about nine months' time. Today diabetic youngsters live out normal life spans and enter all occupations.

Long-acting insulins have wiped out the fear of acute infection due to diabetes. Carbuncles, once very serious, are now uncommon. It was once rare for a woman diabetic to give birth to a live child. Today at least 80 per cent of such children are born alive, and maternal mortality is no different from that of nondiabetic women.

The diabetic in industry no longer faces acute sepsis and prolonged convalescence if he is cut or bruised. This has enabled life insurance companies to issue group life insurance to large groups of persons without considering diabetics among them as added risks.

The control of diabetes with long-acting insulins has enabled some life insurance companies to write policies on diabetics on an extra risk basis. At some future time, when physicians can differentiate the basic cause of diabetes, diabetics may become insurable at standard rates.

While insulin has led to effective control of diabetes, the incidence of the disease has been greater. Essentially, it is a disease of middle and older age. The lengthening of the life span means that more people are living to develop diabetes. At the same time younger diabetics who once would have died of diabetes are living

(*Continued on page* 54)

a standard by which to judge

There is little that *isn't* known about broad-spectrum AUREOMYCIN. Doctors have observed its action against a wide variety of infections involving many types of cases. They have recorded their findings with more than 8,000 papers in the literature. Seven years of use in every medical field confirms these conclusions.

Dosage forms for every medical requirement

OMYCIN*

Hydrochloride
Chlortetracycline HCl *Lederle*

NOW AVAILABLE:

AUREOMYCIN SF

CAPSULES, 250 mg.

For Patients with Prolonged Illness

AUREOMYCIN SF combines effective antibiotic action with vitamin supplementation to shorten convalescence and hasten recovery. One capsule, q.i.d., supplies one gram of AUREOMYCIN and B complex, C and K vitamins in the Stress Formula suggested by the National Research Council. AUREOMYCIN SF Capsules are dry-filled and sealed, contain no oils or paste.

EDERLE LABORATORIES DIVISION *American Cyanamid Company* PEARL RIVER, NEW YORK

*TRADE-MARK

Lederle

DIABETES MELLITUS (Continued)

out their normal years despite the disease. At the present time it is estimated that there are 2,000,000 diabetics, known and unknown in the United States.

Summary of paper by Herbert Pollock, M.D., 64th annual meeting of the Association of Life Insurance Medical Directors of America.

‹ ›

The wrong patient

Two women were discussing their medical problems. One, an insecure individual who attempted to counteract her insecurity by maintaining control over other people, said, "Dr. A. was so arbitrary I couldn't stand him. He would just order me to do this and that and never tell me why. Now I go to Dr. B. who always takes time to explain the reasons for everything he asks me to do."

The other, a rather helpless and dependent person, replied, "I couldn't stand Dr. B's insistence on telling me all about everything that's wrong with me. I finally gave up and went to Dr. A. He makes me feel so safe; I can leave everything up to him and just follow his instructions, and I know things will turn out all right." *C. Knight Aldrich, M.D. Psychiatry for the Family Physician. McGraw-Hill Book Co.,* 1955.

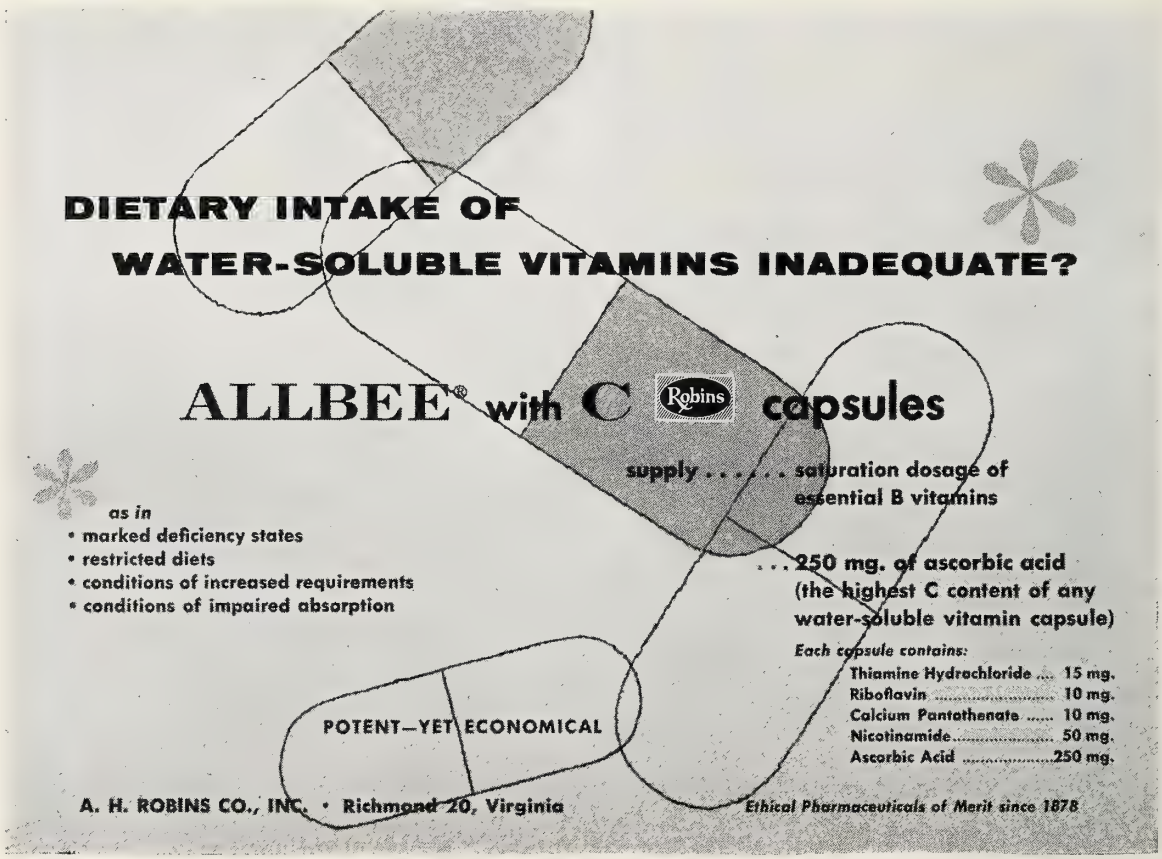
‹ ›

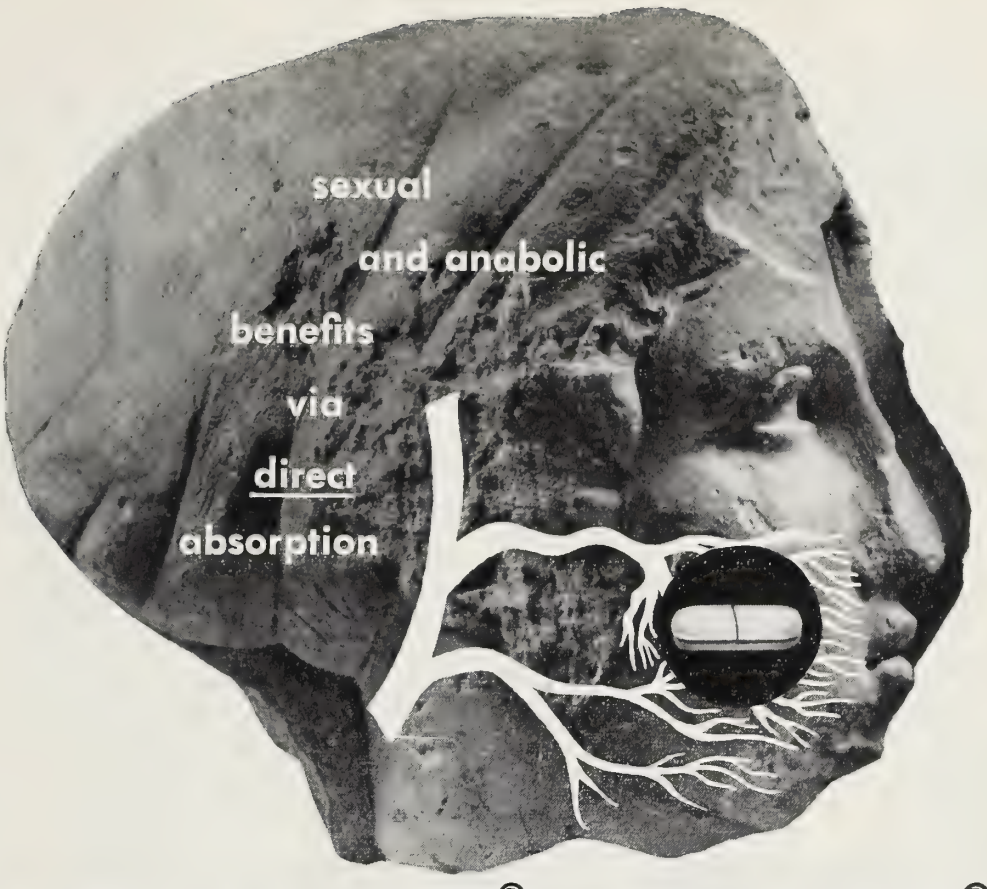
Temperature

An electronic clinical thermometer, which is used like an ordinary thermometer, has been developed. Current from a flashlight battery is passed through metal oxides that are imbedded with wires in the glass rod. The oxides change resistance in precise ratio with the body temperature and give the temperature, accurate to a tenth of a degree, in a 5 second period. *Lee B. Lusted, M.D. Medical Electronics. New England J. Med. April 7,* 1955.

‹ ›

A fresh mind keeps the body fresh. Take in the ideas of the day, drain off those of yesterday. As to the morrow, time enough to consider it when it becomes today. —*Bulwer*





METANDREN® LINGUETS®

the most potent oral androgen

FEMANDREN® LINGUETS®

the most potent oral estrogen with the most potent oral androgen

Buccally or sublingually absorbed LINGUETS by-pass liver inactivation or gastric destruction—are virtually as potent as parenteral steroids—provide effective, convenient, low-cost hormone therapy.

Supply: Metandren Linguets, 5 mg. (white, scored) and 10 mg. (yellow, scored). Femandren Linguets (green, scored), each containing 0.02 mg. ethinyl estradiol and 5 mg. methyltestosterone.

Metandren® (methyltestosterone U.S.P. CIBA)
Femandren® (methyltestosterone with ethinyl estradiol CIBA)
Linguets® (tablets for mucosal absorption CIBA)

C I B A Summit, N. J.

2/ 2079M

MEDICAL HORIZONS TV Monday P.M. *Sponsored by* CIBA ABC-TV

Physicians' estates statistics

A recent study made by the Hartford County (Conn.) Medical Society of 144 obituaries of local physicians and probate court cases involving their estates reveals some illuminating and startling facts which should make any physician do a bit of checking on his own financial status and on just how fair he is being to his own health.

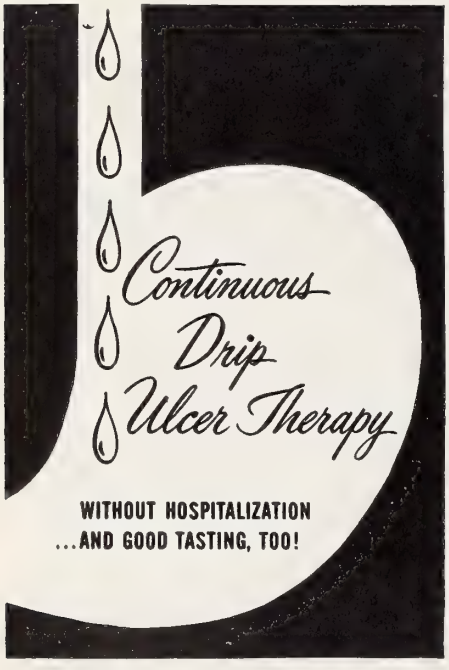
The study revealed the following, according to an article in the Hartford Times and abstracted by the New England Mutual Life Insurance Company's official bulletin, "The Pilot's Log:"

One out of eight of the physicians who died between 1940 and 1953 was in debt at the time of death. Of the 144 doctor estates studied, one out of three . . . left net assets of less than $10,000. The Hartford survey disclosed only one extremely wealthy doctor out of the 144 and that $575,915 of his estate was consumed by estate taxes and other settlement expense.

Only one doctor in eight survived his wife. The doctors aged 40 to 50 died twice as fast as the general population, and in the 60-70 bracket, the doctor's death rate was 50 per cent higher than the insurance table. Heart diseases and cerebral hemorrhage were the chief causes of death. Expense of settlement of the estates studied ranged from a minimum of 13 per cent to as much as one-third. The age at death of the physicians when compared with life insurance mortality tables showed that there were two vulnerable age periods for medical men: 40 to 50 and 60 to 70. One out of three physicians left no will. *Estates of Physicians. New York Med. Sept.* 20, 1955.

‹ ›

Some chronic conditions are preventable; some are deferable; some are curable; and some are modifiable. We know how they are spread and how to prevent their spread. Some conditions, such as diabetes or rheumatic heart disease, are deferable even where there is a tendency toward it, if the appropriate medical care is provided in time. Some conditions, such as pernicious anemia or cerebral hemorrhage, are modifiable. *Daniel Bergsma, M.D., New Jersey, Pub. Health News, April, 1955.*



HORLICKS CORPORATION
Pharmaceutical Division
RACINE, WISCONSIN

Nulacin

A recent clinical study* of 46 ambulatory nonhospital patients treated with Nulacin† and followed up to 15 months describes the value of ambulatory continuous drip therapy by this method. Total relief of symptoms was afforded to 44 of 46 patients with duodenal ulcer, gastric ulcer and hypertrophic gastritis.

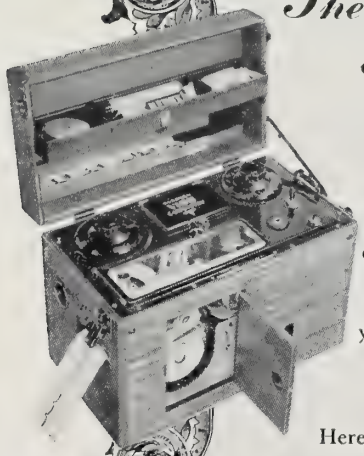
The delicately flavored tablets dissolve slowly in the mouth (not to be chewed or swallowed). They are not noticeable and do not interfere with speech.

Nulacin tablets are supplied in tubes of 25 at all pharmacies. Physicians are invited to send for reprints and clinical sample.

*Steigmann, F., and Goldberg, E.: Ambulatory Continuous Drip Method in the Treatment of Peptic Ulcer, Am. J. Digest. Dis. 22:67 (Mar.) 1955.

†Mg trisilicate 3.5 gr.; Ca carbonate 2.0 gr.; Mg oxide 2.0 gr.; Mg carbonate 0.5 gr.

There can be "extra dividends" on an ECG *investment*



Sanborn Viso-Cardiette

If you are considering purchase of an electrocardiograph, it may seem to you that all makes are "pretty much alike", since none can do more for you clinically than produce an electrocardiogram. Looking at it from an investment point of view, you *expect* your instrument to pay you good dividends in the form of specific benefits to you and your patients. But, investments that pay *extra dividends* are the happy ones. Here are a few that go with Viso-Cardiette ownership.

KNOWN dependability

Initial thinking in considering an ECG should reach beyond favorable first impressions to the instrument's potential continuity of service. There the best yardstick is to inquire among those of your colleagues or associates who own electrocardiographs. You will soon learn that the name "SANBORN" is synonymous with "dependability", which is an understandable result of over 30 years of specialization in the design and manufacture of this type of precision instrument.

DIRECT responsibility

There are many "extra dividends" in dealing directly with the maker of your ECG. The interest in and responsibility towards you as the user is with Sanborn Company instead of an intermediate source. There is a standardization of prices, and the cost is the same to all. Also, the Viso user can avail himself of direct contact with the designers of his instrument, and his local serviceman is, more likely than not, a SANBORN man, full-time and factory-trained.

EXCLUSIVE Service Helps

Every alternate month all Viso owners receive, free of charge, the Sanborn Technical Bulletin which contains much helpful data on operating procedure, maintenance, ideas and techniques developed by others, and the like — all prepared by an experienced staff. In addition, a five-part Sanborn Service Course by correspondence is available for technicians principally, who wish technical information a bit beyond the preliminary Instructions. No other ECG maker offers these "extra dividends" in Service.

Ask for details of a 15-day, no-obligation clinical test plan.

Sanborn Company

CAMBRIDGE 39, MASSACHUSETTS

CHICAGO *Branch Office,* 2040 Lincoln Park West, Bittersweet 8-3737

More for health

Compared with last year, the Department of Health, Education, and Welfare is spending 32 per cent more in the health fields. The increase — $127,754,900 — is explained largely by sharp boosts in funds for Hill-Burton hospital construction, for vocational rehabilitation, for medical research, and for the medical care of the indigent, and by a $30 million appropriation to purchase Salk vaccine and finance inoculation campaigns. Total federal health spending also will reach a new high of over two and one-quarter billion dollars during the current fiscal year, about $2,268,800,000 — a 6.4 per cent increase over last year. Even in a national health budget well up in the billions, this figure for federal medical-health spending is not inconsequential. It is about 15 times the amount needed to maintain Congress and the federal courts, 14 times the total budget of the State Department, and four times more than is spent by either the Labor Department or the Post Office Department. Expressed another way, Uncle Sam puts up $15 of every $100 spent by the American people (publicly or privately) for health and medical purposes, from purchase of toothpaste to financing cancer research. *Special Report* 84-15, *Amer. Med. Assn. Oct.* 14, 1955.

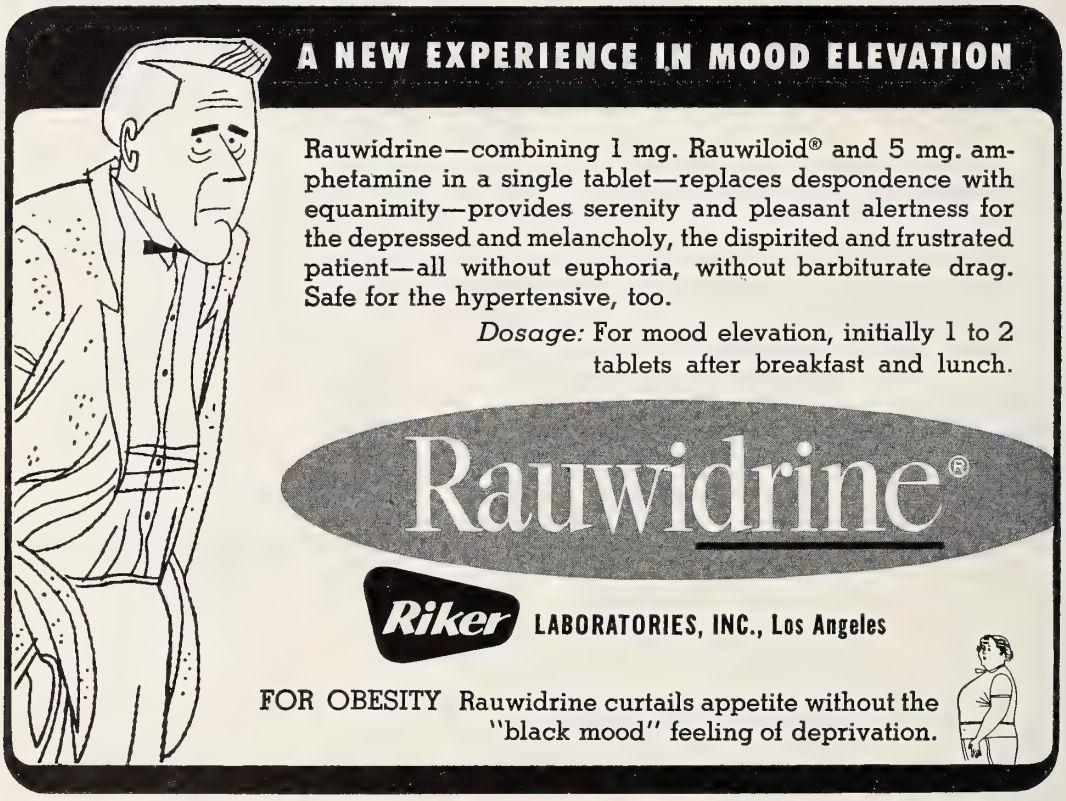
‹ ›

Peptic ulcer in oldsters

Some interesting points are found with regard to the location of peptic ulcer in older patients. In the population as a whole there probably are 10 duodenal ulcers to every gastric ulcer. In the aged, this ratio falls to about 3.5:1. Some correlation may exist between gastric ulcer and degenerative arterial disease which may be of clinical importance, especially in connection with the cause of gastric ulcer and the seriousness of bleeding from them. *Albert M. Snell, M.D. Digestive Ailments of Older Patients. Minnesota Med. May* 1955.

‹ ›

Nothing is ever lost by courtesy. It is the cheapest of the pleasures; costs nothing and conveys much. It pleases him who gives and him who receives and thus, like mercy, is twice blessed.—*Erastus Wiman*



in rheumatoid arthritis

- greater therapeutic benefits
- fewer unwanted effects

METICORTELONE

PREDNISOLONE, SCHERING

METICORTELONE resembles METICORTEN in antirheumatic, anti-inflammatory and antiallergic effectiveness.[1-11] The availability of these new steroids, first discovered and introduced by Schering, provides the physician with two valuable agents for safer, more effective cortical hormone therapy.

Bibliography: (1) Bunim, J. J.; Pechet, M. M., and Bollet, A. J.: J.A.M.A. *157*:311, 1955. (2) Waine, H.: Bull. Rheumat. Dis. *5*:81, 1955. (3) Tolksdorf, S., and Perlman, P.: Fed. Proc. *14*:377, 1955. (4) Herzog, H. L., and others: Science *121*:176, 1955. (5) Bunim, J. J.; Black, R. L.; Bollet, A. J., and Pechet, M. M.: Ann. New York Acad. Sc. *61*:358, 1955. (6) Henderson, E.: New developments in steroid therapy of rheumatic diseases, presented at New Jersey State Medical Society Meeting, Atlantic City, New Jersey, April 17-20, 1955. (7) Boland, E. W.: California Med. *82*:65, 1955; abs., Curr. M. Digest *22*:53, 1955. (8) King, J. H., and Weimer, J. R.: A.M.A. Arch. Ophth. *54*:46, 1955. (9) Criep, L. H.: Prednisolone and prednisone in the treatment of allergic diseases, to be published. (10) Sternberg, T. H., and Newcomer, V. D.: Am. Pract. & Digest Treat. *6*:1102, 1955. (11) Gordon, D. M.: Prednisone and prednisolone in ocular disease, to be published.

Schering

METICORTELONE,* brand of prednisolone, Schering.
METICORTEN,* brand of prednisone, Schering.
*T. M.

ML-J-59

The neophyte

It is easy to speculate about the nature of circumstances in medical education which might possibly foster the formation of attitudes (in medical students) and other seemingly unhygienic reaction tendencies which have been noted. These speculations now lack corroboration; but the kinds of experience which might possibly be important and whose effect should be assessed are such occurrences as the initial experiences with the cadaver, with the death of a patient, and with chronic or hopeless disease. Also important are initial experiences with physical, gynecological, or rectal examinations of patients of the same and opposite sex, autopsies, venereal patients, lumbar punctures, etc. Of interest are such things as the fear of error in diagnosis or prescription, the fear of contagion, the threat of failure in school, protracted sexual conflicts, the conflict between research and practice, the long-term conflict over the dependent role the student usually must assume, the effect of limited recreational and social outlets, the growing realization of the student that persons will do implicitly what he orders despite his own sense of inadequacy in dealing with their problems. *Leonard D. Eron, M.D. Effect of Medical Education on Medical Students' Attitudes. J. Med. Education, Oct.* 1955.

‹ ›

Brittle nails

Chemical analysis of brittle nails failed to reveal any decrease in mineral content—results which confirm the long held view of dermatologists that there is no basis for the administration of calcium to patients with brittle nails. *Herbert Rattner, M.D. What's New and What's True of What's New in Dermatology. California Med. July 1955.*

‹ ›

Most public health people believe today that good health cannot be forced upon individuals, but when they are educated to its advantages and its values, they work to secure its benefits for themselves, their families and their communities. Leroy E. Burney, M.D., Am. J. of Pub. Health, Feb., 1955.

Lederle

FOLBESYN*

Vitamins *Lederle*

A well-balanced, high-potency vitamin formula containing B-Complex and C

FOLBESYN provides B-Complex factors (including folic acid and B_{12}) and ascorbic acid in a well balanced formula. It does not contain excessive amounts of any one factor.

FOLBESYN Parenteral may be administered intramuscularly, or it may be added to various hospital intravenous solutions. It is useful for preoperative and postoperative treatment and during convalescence.

Dosage: 2 cc. daily. Each 2 cc. provides:

Thiamine HCl (B_1)	10 mg.
Sodium Pantothenate	10 mg.
Niacinamide	50 mg.
Ribloflavin (B_2)	10 mg.
Pyridoxine HCl (B_6)	5 mg.
Ascorbic Acid (C)	300 mg.
Vitamin B_{12}	15 micrograms
Folic Acid	3 mg.

FOLBEYSN is also available in tablet form, ideal for supplementing the parenteral dose.

LEDERLE LABORATORIES DIVISION AMERICAN Cyanamid COMPANY Pearl River, New York

*REG. U.S. PAT. OFF.

After Bread Comes Wine...

*The Second Legacy of the Creator**

From the very dawn of history, wine, the classic beverage of moderation, has been acclaimed for its appetite-stimulant properties, its role in nutrition, its function as an aperitif.

However, until quite recently no serious attempt was made at a scientific objective study of the rationale of wine as a nutritional or medicinal agent.

Recently, in response to a demand within the medical profession that fact be separated from folklore, the Wine Advisory Board decided to institute a series of studies to determine the true therapeutic niche of wine based on a more accurate knowledge of its chemical constituents, its physiological and pharmacological actions.

The results to date have been most gratifying. For example, we have learned that—

—Wine stimulates olfactory acuity—markedly increasing appetite in anorexia;

—Wine increases appreciably not only the volume but the proteolytic power of gastric juice, thereby encouraging digestion notably in convalescents and older patients;

—Wine serves as a quick-energy food. Its small amount of hexose is speedily absorbed and its moderate content of alcohol is metabolized readily even by diabetics;

—Wine possesses significant vasodilating, diuretic and relaxing properties of value in the field of cardiology;

—A little Port or Sherry at bedtime is a valuable relaxant to the insomniac and may obviate the need for sedative medication.

And wine can help brighten the often unappealing character of special or restricted dietaries—a psychological boost of inestimable value to the debilitated and depressed patient.

We believe you will find "Uses of Wine in Medical Practice" a valuable addition to your files. A copy is available to you at no expense, by writing to: Wine Advisory Board, 717 Market Street, San Francisco 3, California.

*Georges Ray, Vins de France, Paris, University Press, 1946 (p. 75).

FAIRVIEW
Sanitarium

DEVOTED TO THE ACTIVE TREATMENT OF

MENTAL and NERVOUS DISORDERS

Specializing in Psycho-Therapy, and Physiological therapies including:

- Electro-Shock
- Electro-Narcosis
- Insulin Shock
- Carbon Dioxide Therapy

Out Patient Shock Therapy Available

ALCOHOLISM Treated by Comprehensive Medical-Psychiatric Methods.

2828 S. PRAIRIE AVENUE, CHICAGO 16 J. DENNIS FREUND, M. D., Medical Director

Phone Victory 2-1650 Registered by the American Medical Assn.

Irradiated food

Developments in radiation sterilization of foods received wide attention at the 15th Annual Meeting of the Institute of Food Technologists in Columbus, Ohio, last month. At present there are more limiting factors than promising possibilities, but speakers reminded the food technologists that these are pioneer days in the radiation era. Present status in general is: High voltage cathode rays will sterilize a wide variety of foods in a matter of seconds. However, at high levels, undesirable changes in flavor, color, and odor occur in most foods. The inactivation of enzymes requires more exposure than do the micro-organisms that are common causes of food spoilage. Clostridium botulinum, the most dreaded of the organisms attacking food, requires varying dosages according to type, but all are on the extreme side. Nutritional effects are not yet fully assessed but the picture is not too dark, on the basis of preliminary returns.

Proctor and associates from Massachusetts Institute of Technology reported that cathode ray treatment of meat and vegetable products can extend storage life at refrigerator temperatures above freezing from several weeks to several months. At the University of Michigan, L. W. Brownell and H. A. Harlin have found that gamma radiation of cake, bread, and all purpose flours at a fairly low dosage (20,000 rep) did not affect baking properties of the flours, and that insects and weevils were destroyed. Eggs of insects also were made sterile at this level of treatment. Dr. Charles Glen King, Scientific Director, The Nutrition Foundation, Inc., reviewed studies of the effects of radiated foods fed to animals. A vitamin E deficiency developed when irradiated meat was included in the experimental diet. However, no evidence of specific abnormalities were observed in the tissues of the experimental animals. Drs. G. M. Dack and R. O. Wagenaar, Food Research Institute, University of Chicago, have found high resistance to irradiation in Clostridium botulinum spores inoculated into surface ripened cheese. It took 800,000 to 1,100,000 rep to in-

(*Continued on page* 64)

in whooping cough

ELIXIR BROMAURATE

GIVES EXCELLENT RESULTS

Cuts short the period of illness and relieves the distressing spasmodic cough. Also valuable in Bronchitis and Bronchial Asthma.

In four-ounce original bottles. A teaspoonful every 3 to 4 hours

Prescribed by Thousands of Doctors

GOLD PHARMACAL CO. NEW YORK CITY

KARO SYRUP

BELONGS IN THIS PICTURE!

...a carbohydrate of choice
in milk modification for 3 generations

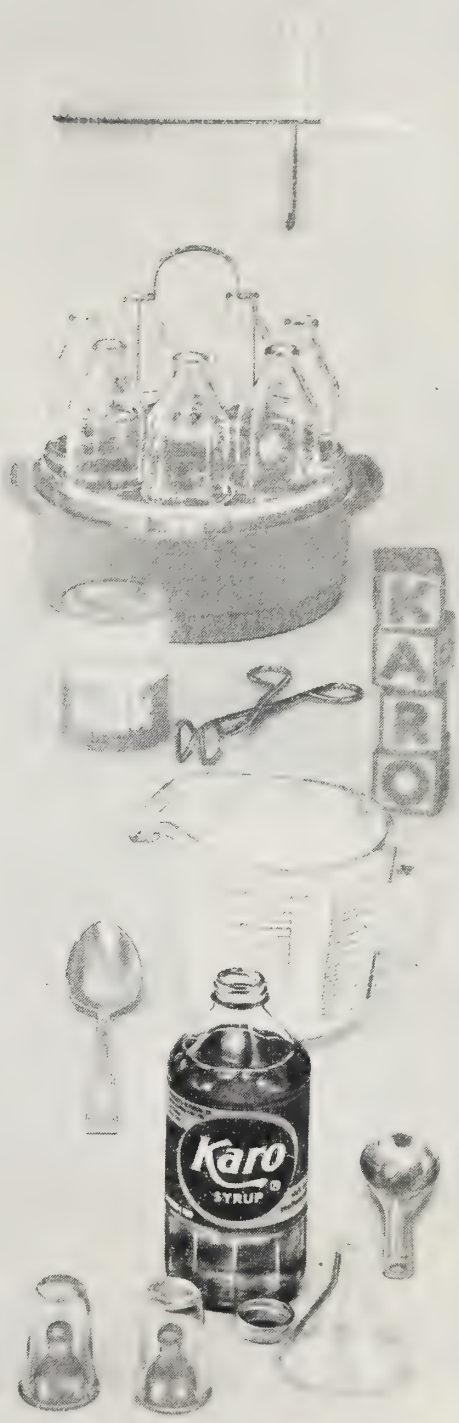
OPTIMUM caloric balance—60% of caloric intake, gradually achieved in easily assimilable carbohydrates—is assured with Karo. Milk alone provides 28%, or less than half the required carbohydrate intake.

A MISCIBLE liquid, Karo is quickly dissolved, easy to use, readily available and inexpensive.

A BALANCED mixture of dextrins, maltose and dextrose, Karo is well tolerated, easily digested, gradually absorbed at spaced intervals and completely utilized.

PRECLUDES fermentation and irritation. Produces no reactions, hypoallergenic. Bacteria-free Karo is safe for feeding prematures, newborns, and infants—well and sick

LIGHT and dark Karo are interchangeable in formulas; both yield 60 calories per tablespoon.



CORN PRODUCTS REFINING COMPANY
17 Battery Place, New York 4, N. Y.



The NORBURY SANATORIUM

JACKSONVILLE, ILLINOIS — INCORPORATED and LICENSED

For the Treatment of Nervous and Mental Disorders

FRANK GARM NORBURY, M.D., Medical Director
HENRY A. DOLLEAR, M.D., Superintendent
FRANK B. NORBURY, M.D., Associate Physician

Address Communications — THE NORBURY SANATORIUM, Jacksonville, Illinois

IRRADIATED FOOD (Continued)

activate type A spores; 550,000 rep to inactivate type B. At high toxin levels, 7,800,000 rep were required.

For those expecting an answer to the question: How far is radiation sterilization from the goal of commercial use, the candid answer would have to be expressed in terms of years. *Radiation Sterilization. J. Am. Dietet. A. July* 1955.

‹ ›

Define the term

Any talk on the social and economic aspects of a medical problem has to reach some definitions of the various factors involved. Here we would like to define such terms as "long-run illness" and "ability to pay." When we attempt to do so we find that both are variables and much dependent one on the other. Obviously, ability to pay decreases with the length of an illness and vice versa. The majority of middle income people can pay the costs of short-term illness without any real difficulty, while only the upper income groups, or perhaps 10 per cent of the nation, can get by an illness of several months or years without serious financial embarrassment. *I. Jay Brightman, M.D. Medicsocial and Economic Aspects of the Long-term Illness Problem. New York J. Med. May* 1, 1955.

‹ ›

Too much digitalis

Overdigitalization can be the cause of increasing cardiac decompensation. This is often accompanied by premature ventricular contractions, arrythmias, and various degrees of heart block. With digitoxin there are often cardiac signs before nausea, vomiting, and ocular difficulties supervene. Therefore, despite increasing congestive failure, it may be necessary to withdraw the digitalis. The speed of elimination of digitalis preparations differs markedly. It may take 10 to 14 days to eliminate a toxic dose of digitalis. A toxic dose of digoxin, on the other hand, may be eliminated in 36 to 48 hours. Therefore, the type of digitalis preparation is important in assessing how long the patient will be off the drug. *John F. Currin, M.D. Problems in the Treatment of Refractory Cardiac Failure. Arizona Med. May 1955.*

North Shore Health Resort

on the shores of Lake Michigan
WINNETKA, ILLINOIS

NERVOUS and MENTAL DISORDERS
ALCOHOLISM and DRUG ADDICTION

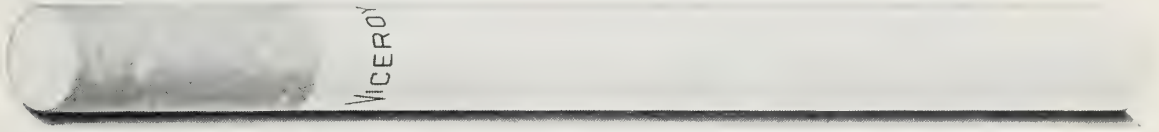
Modern Methods of Treatment
MODERATE RATES

Established 1901 — *Fully Approved by the*
Licensed by State of Illinois — *American College of Surgeons*

SAMUEL LIEBMAN, M.S., M.D.
Medical Director

225 Sheridan Road — Winnetka 6-0211

In a Filter Cigarette... it's the Filter You Depend on



The VICEROY filter tip contains 20,000 tiny filter traps, made through the solubilization of pure natural material. This is twice as many of these filter traps as any other brand.

We believe this simple fact is one of the principal reasons why so many doctors smoke *and* recommend VICEROY—the cigarette you can *really* depend on!





King-Size Filter Tip **VICEROY**



World's Most Popular Filter Tip Cigarette
Only a Penny or Two More
Than Cigarettes Without Filters

Mercy Hospital Institute of Radiation Therapy

The Henry Schmitz Medical Group

For Appointment
Victory 2-4700, Ext. 170 or RAndolph 6-4444

Herbert E. Schmitz, M.D., *Director*
Peter A. Nelson, M.D., *General Oncology*
Henry L. Schmitz, M.D., *Internal Medicine*
Janet Towne, M.D., *Gynecology*
Robert L. Schmitz, M.D., *General Surgery*
John F. Sheehan, M.D., *Pathologist*
Charles J. Smith, M.D., *Gynecology*
Charles S. Gilbert, M.D., *Internal Medicine*
William F. Cernock, M.D., *Internal Medicine*
Fred W. Eims, *Physicist*
Miss Hilda Waterson, R.N.
Helen Hansen, *Social Service*

COMPLETE TUMOR THERAPY
Including
SUPERFICIAL X-RAY THERAPY
DEEP X-RAY THERAPY up to 1,000 K.V.
RADIUM THERAPY

Daily Consultation at Institute
Tumor Clinic—Mercy Free Dispensary—Tuesday at 9 a. m.
Tumor Conference — J. B. Murphy Auditorium — Friday at 1 p. m.

THE MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA

the doctor's most secure source of security

PROFESSIONAL PROTECTION EXCLUSIVELY SINCE 1899

CHICAGO Office:
T. J. Hoehn, E. M. Breier and W. R. Clouston, Representatives,
1142-44 Marshall Field Annex Building,
Telephone State 2-0990

SPRINGFIELD Office:
F. A. Seeman, Representative,
Telephone Springfield 4-2251

The need for security

Every individual has a basic need for security and affection that is as important to the total state of health as is the basic need for food, oxygen, and water. Every individual has impelling drives, differing at various ages and levels of development, which must pass the censorship of the mores of the culture in which he lives and the conscience which he has developed. Psychological conflict develops when two or more dynamic tendencies strive simultaneously for incompatible goals. The resultant lack of satisfaction, the frustration, and the anxiety lead to symptom formation if the drives are sufficiently imperative and a constructive compromise solution canot be achieved. *W. T. Thompson, Jr., M.D. Office Management of the Neurotic Patient. West Virginia M.J. May 1955.*

‹ ›

Variety for the diabetic

The ADA Diet provides every variety of food which the nondiabetic patient normally eats, except sugar. Substitutes for this form of carbohydrate, such as Sucryl® and crystallose, are real improvements over saccharin with its bitter after taste. Diabetic candy and soft drinks such as ginger ale, orange and root beer made with a sugar substitute also are now on the market. These are useful especially in children to help eliminate the feeling of being different. It must be emphasized that these are substitute items. The patient should not only adhere to his designated diet but know it so well he can eat in public gatherings in complete ease. *Carl S. Nadler, M.D. Some Practical Aspects of the Dietary Treatment of Diabetes Mellitus. J. Louisiana M. Soc. May* 1955.

‹ ›

If one should give me a dish of sand, and tell me there were particles of iron in it, I might look for them with my eyes, and search for them with my clumsy fingers, and be unable to detect them; but let me take a magnet and sweep through it, and how would it draw to itself the almost invisible particles by the mere power of attraction! The unthinkful heart, like my finger in the sand, discovers no mercies; but let the thankful heart sweep through the day, and as the magnet finds the iron, so it will find in every hour some heavenly blessings.

—*Henry Ward Beecher*

"I've sold a good many cars, and I expect to be selling for years to come!"



"Old age" is getting harder to define. Some of today's working men and women can claim 40, 50, or even more years of experience in their fields—and they're still not ready to retire! To help keep such vigorous folks fit and on the go, many doctors prescribe GEVRAL, a potent dietary supplement prepared specially for geriatric use.

Gevral*

Geriatric Vitamin-Mineral Supplement *Lederle*

Lederle LEDERLE LABORATORIES DIVISION AMERICAN Cyanamid COMPANY Pearl River, New York

Each GEVRAL capsule contains:

Vitamin A	5000 U.S.P. Units	Choline Dihydrogen Citrate	100 mg.	Calcium (as $CaHPO_4$)	145 mg.
Vitamin D	500 U.S.P. Units	Inositol	50 mg.	Phosphorus (as $CaHPO_4$)	110 mg.
Vitamin B_{12}	1 mcgm.	Ascorbic Acid (C)	50 mg.	Boron (as $Na_2B_4O_7.10H_2O$)	0.1 mg.
Thiamine Mononitrate (B_1)	5 mg.	Vitamin E (as tocopheryl acetates)	10 I. U.	Copper (as CuO)	1 mg.
Riboflavin (B_2)	5 mg.	Rutin	25 mg.	Fluorine (as CaF_2)	0.1 mg.
Niacinamide	15 mg.	Purified Intrinsic Factor Concentrate	0.5 mg.	Manganese (as MnO_2)	1 mg.
Folic Acid	1 mg.	Iron (as $FeSO_4$)	10 mg.	Magnesium (as MgO)	1 mg.
Pyridoxine HCl (B_6)	0.5 mg.	Iodine (as KI)	0.5 mg.	Potassium (as K_2SO_4)	5 mg.
Ca Pantothenate	5 mg.			Zinc (as ZnO)	0.5 mg.

Other Lederle geriatric products include: GEVRABON* Vitamin-Mineral Supplement Liquid with a wine flavor: GEVRAL* Protein Vitamin-Mineral-Protein Supplement Powder; and GEVRINE* Vitamin-Mineral-Hormone Capsules.

Both hands

It wasn't until I had begun practicing the specialty of gynecology and was safely in the sanctity of my own office that I had the temerity to deviate from the long established custom and attempt examination with my right hand. Immediately, it seemed as if a whole new horizon had unfolded itself before me and it enabled me to discern pathology which previously had been elusive to the fingers of my left hand. There was no comparison in the tactile accuracy for the right side of the pelvis but I noted at the same time that it was not quite so easy to feel the left side of the pelvis with the right hand. Therefore, I concluded that in cases of doubt it would be more prudent to utilize both hands since there are few who will not agree that it it easier to feel the left side of the pelvis with the left hand and the right side of the pelvis with the right hand and it is, therefore, more rational and accurate to employ both. *Charles B. Marek, M.D. Pelvic Examination — What Price Hand? Maryland M.J. Oct.* 1955.

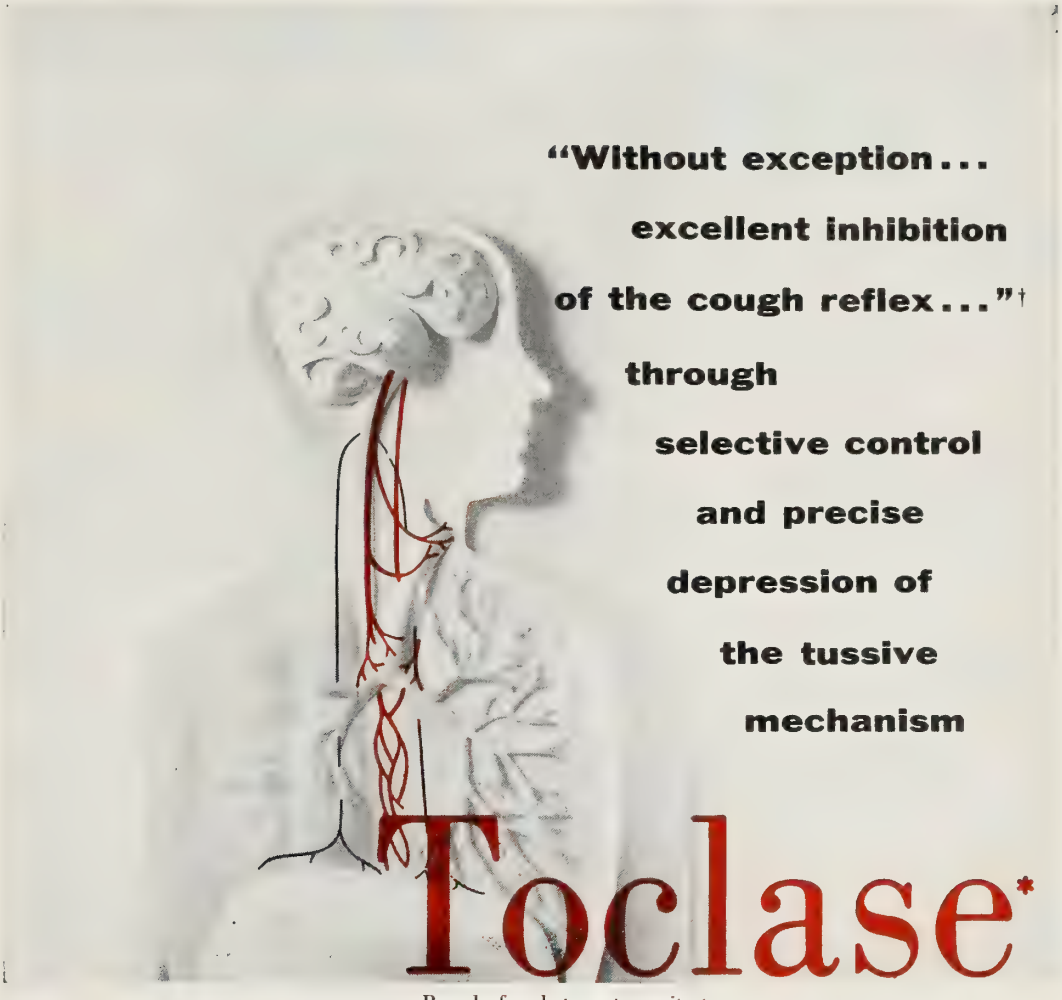
Anemia and CA of bowel

Toxemia or anemia or both are frequent accompaniments of large, ulcerating lesions of the right portion of the colon and may be the only symptoms. Why anemia should occur so frequently has occasioned much conjecture, and many theories have been advanced to explain it. The most plausible explanation seems to be that it results from a combination of absorption of noxious substances such as bacterial toxins and proteins with hemolytic properties and insidious but direct loss of blood from the ulcerated area. *Charles W. Mayo, M.D. and Donald R. Davis, M.D. Neoplasms of the Colon. Postgrad. Med. June* 1955.

‹ ›

Until such time as some means is discovered to prevent tuberculosis which is as effective as the vaccine for smallpox, the X-ray remains our main weapon in the fight against tuberculosis insofar as finding unsuspected case is concerned. G. C. Brink, M.D., Canad. J. Pub. Health, May, 1954.





Brand of carbetapentane citrate

Non-narcotic, non-constipating, non-sedating, non-nauseating, but HIGHLY SELECTIVE and HIGHLY EFFECTIVE

TOCLASE EXPECTORANT COMPOUND Reduces the frequency and intensity of unnecessary cough . . . moderates, but does not abolish purposeful, productive cough. Sugar free. Pleasant-tasting, cherry-flavored, amber color syrup. Bottles of one pint.

TOCLASE SYRUP Controls hyperactive, irritating cough. Pleasant-tasting, cherry-flavored, red color syrup.

for convenience at work or recreation
TOCLASE TABLETS 25 mg. tablets, bottles of 25.

†Parish, F. A.: M. Times *83*:870 (Sept.) 1955.

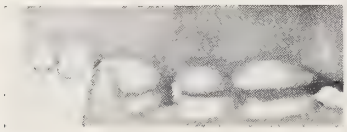
*TRADEMARK

Pfizer

PFIZER LABORATORIES, *Division, Chas. Pfizer & Co., Inc.*, Brooklyn 6, N. Y.

THUMBSUCKING

since infancy caused this malocclusion.



THUM TRADE MARK

THUM broke the habit and teeth returned to normal position.

ACCEPTED FOR ADVERTISING IN PUBLICATIONS OF THE AMERICAN MEDICAL ASSOCIATION

Get Thum at your druggist or surgical dealer.
Prescribed by physicians for over 20 years.

BELLEVUE PLACE

For
NERVOUS and MENTAL
DISEASES

★

Edward Ross, M.D., Medical Director
BATAVIA PHONE
ILLINOIS BATAVIA 1520

Classified Ads

RATES FOR CLASSIFIED ADVERTISEMENTS—For 30 words or less: 1 insertion, $3.00; 3 insertions, $8.00; 6 insertions, $14.00; 12 insertions, $24.00; from 30 to 50 words: 1 insertion, $4.00; 3 insertions, $10.50; 6 insertions, $20.00; 12 insertions, $30.00. Extra words: 1 insertion 10c each; 3 insertions, 25c each; 6 insertions, 40c each; 12 insertions, 50c each. A fee of 25c is charged for those advertisers who have answers sent care of the Journal. Cash in advance must accompany copy.

FOR SALE: Bircher diathermy (F.C.C. approved), Bircher Hypecator; Fischer ultra-violet lamp (cold quartz); Fischer "Space-saver" 75 MA x-ray with bucky & floroscopy & other x-ray equip; Hot Point refrigerator (apt. size); Leitz monocular microscope; Olympus monocular microscope; E. E. Peters, M.D., 212 Linn St., Muscatine, Iowa. Ph: AM-3-8814.

WANTED: Anesthesiologist, Ill. license wishes perm. connection with group or hosp. in Ill. Married, U. S. citizen, 3 year approved Northwestern Univ. resid. two years practice. Best references. Box 230, Ill. Med. Jl. 185 N. Wabash Chicago 1, Ill.

WANTED: Gen'l surgeon completing surgical resid. at a University Hosp. Dec. 1955 desires assoc. with surgeon or small group. Board eligible. Veteran. Married. Age 31. Avail Jan. 1956. Box 231, Ill. Med. Jl. 185 N. Wabash Ave., Chicago 1, Ill.

VACANCIES in Ill. Mental Hospitals: Staff physicians, Psychiatrists, Tuberculosis Control Physicians — Salary range $380-$860 per month. Assist. superintendents and Clinical Directors — Salary range $660-$980 per month. Nominal deduction for comp. maint. Lib. pension plan, Civil Service, sick leave, annual paid vacation. Requirements: grad. from approved American, Canadian, or foreign med. schl. & one year rotating internship. Grads. of foreign med. schools who have only an internship in a foreign country must possess license to pract. in some state or country. Contact Paul Hletko, M.D. Chief Medical Officer, Ill. Dept. of Public Welfare, 160 N. LaSalle St., Chicago, Ill. 2/56

FOR SALE: High volume, gen'l practice in growing suburb west of Chicago. Available for purchase or association. Hospital staff appointment. Call Mrs. Mason, STate 2-2282.

WANTED: Young gen'l pract. in new air-cond. clinic. Starting salary $600 per month plus comm. Partnership to follow after probat. period. Box 229 Ill. Med. Jl. 185 N. Wabash, Chicago 2.

PEDIATRICIAN: 31- board elig.-category 4. Married, one child. Trained Cook County Hosp. & Children's Memorial Hosp., Chicago. Priv. pract. experience. Desires location in Illinois. (Midwest) Box 228. Ill. Med. Jl. 185 N. Wabash Ave., Chicago 2.

FOR RENT: Three air-cond. suites. Three attract. functional rooms each. For non-competing M.D.'s. Busy ethical pharmacist will cooperate. Estab. over 40 years. Deitch Pharmacy, 1800 W. Chicago Ave., HU 6-2937.

If he is normal?

Accident prevention at home demands three essentials: forethought, time, and discipline. Forethought demands that at any age, the child's interests and abilities be anticipated. Considering those curiosities and capabilities, a prediction of the child's probable conduct should indicate what protective measures will be necessary, and in what areas of activity instruction will keep him out of serious accidents. A year old baby is hardly prepared for the complexities and artificial rules of the world within his reach. He can be expected to reach every closet and cupboard in the house, to indiscriminately taste, touch, chew, pull on, jerk, bite, and swallow every article he can reach, put his foot or head into every situation and every machine he can find. If he is normal he also will be unafraid of water even it it is 3,000 feet deep; undeterred by autos and tractors, even if they are 3,000 pounds heavy; and ignorant of the potentialities of fire if it is 3,000 degrees hot. *Editorial. Accidents in Childhood. J. Tennessee M. A. Sept.* 1955.

‹ ›

The priceless treasure of boyhood is his endless enthusiasm, high store of idealism, his affections, and his hopes. When we preserve these, we have made men. We have made citizens, and we have made Americans.

—*Herbert Hoover*

THE KEELEY INSTITUTE
DWIGHT, ILLINOIS

Treating alcoholism and other problems of addiction.
REGISTERED BY THE AMERICAN MEDICAL ASSOCIATION—
MEMBER AMERICAN HOSPITAL ASSOCIATION.

44950

Illinois medical journal.
AUTHOR

v.107-108, 1955
TITLE

DATE DUE | BORROWER'S NAME

44950

Illinois medical journal.
v.107-108, 1955

RETURN THIS BOOK ON OR BEFORE LAST DATE STAMPED